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TABLE OF CONTENTS

	PAGE
Extra-Mural and Intra-Mural Practice—Then and Now, <i>Samuel A Levine, M.D.</i>	363
Medical Leadership, <i>Presidential Address, Arthur H. Ruggles, M.D.</i>	369
Profound Prerenal Azotemia Resulting From Pyloric Stenosis, Report of Case, <i>Aaron T. Beck, M.D.</i>	372
Proposed Draft of Physicians, Report of Bureau of Legal Medicine of the AMA	382
In the Event of a National Emergency	401

EDITORIALS

Navy Pollution in Narragansett Bay	375
What's Wrong With the Profit Motive	376

DEPARTMENTS

Appointed Committees, 1948, R. I. Medical Society	410
Book Reviews	412
Child Health Services Study by American Academy of Pediatrics	411
District Medical Society Meetings	397
Health Insurance Committee Report	378
House of Delegates, Report of May 5, 1948 Meeting	388
Woman's Auxiliary	407

MISCELLANEOUS

Index of Advertisers	409
Record Librarians Elect	409

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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXI

JUNE, 1948

NO. 6

EXTRA-MURAL AND INTRA-MURAL PRACTICE—THEN AND NOW*

SAMUEL A. LEVINE, M.D.

The Author. *Samuel A. Levine, M.D. of Boston, Mass. Physician, Peter Bent Brigham Hospital; Assistant Professor of Medicine, Harvard University Medical School.*

M R. PRESIDENT, Members of the Providence Medical Association and Friends—I chose a rather odd title for my talk tonight. It is a sort of noncommittal subject that gives me plenty of leeway to ramble. This is the hundredth year celebration of your society, and it gives us an opportunity to look back on an entire century. You can quickly see what a difference there is between the role of the practitioner then and now. About all he could do one hundred years ago he could very well do at his office or in the patient's home. Very little was lost as far as the welfare of the patient was concerned if he overlooked many of the conditions that were then prevalent: Just think of how that has all changed now.

To obtain some picture as to what was going on in 1848, I looked over some of the issues of the Boston Medical and Surgical Journal of that year. As you can quickly guess, the articles concentrated their attention on infectious diseases, midwifery and a great variety of drugs and bizarre therapeutic procedures. Just about this time ether was discovered and that began to attract attention. In the first issue of that year there was an article on "Rattlesnakes" and the various treatments employed for snake poison. All sorts of concoctions were used; decoction of viola ovata, juice of purple bind weed, olive oil externally and internally. In another article on Typhus Fever by Dr. Silas Brown the author states that 'blistering the arms nigh to the shoulder is superior to my old custom of blistering the scalp'. Although we still have no specific treatment for typhus or typhoid fever, we at least know what not to do. Another paper was published by Daniel Holt, M.D. and R. Stackford, M.D., entitled

"The Dysentery as it Appeared in Lowell in 1847, Homeopathically Treated". A great variety of medicaments was employed, one type for one stage of the dysentary and another for a different stage. Amongst the drugs mentioned were aconite, colo-cynth, mercury, nux vomica, arsenic and rhus toxicodendron. Then there was an article on "Etherization" and another on "Clinical Records and Post-Mortem Illustration of Typhus or Ship Fever". Ship fever was a mixture of typhoid and typhus fever, for both were prevalent in New England one hundred years ago and the two were not clearly differentiated until later. A paper by Dr. S. Clapp of Pawtucket also appeared "On the Pathology of Diabetes Mellitus" in which he claimed it was due to a disease of the brain. Then there were articles such as "Etherization in Labor" and "A Case of Labor, Complicated with Cervical Presentation and Uterine Tumor", discussing how that was managed.

The point of all this is that with the knowledge available at that time the physician could do everything he could, either in his office or in the patient's home. The main purpose of a hospital was to isolate infectious cases, especially smallpox, and to serve as an almshouse for the very poor. There were no special examinations or therapeutic procedures that could be done there that could not be performed at home. The situation obviously is entirely different at the present time, with the result that hospital space is required more and more for additional work to be done, either diagnostic or therapeutic. The situation is not likely to lighten, as the demand for more involved observation and methods of treatment is more apt to increase as time goes on.

With the great increase in medical knowledge that has taken place these past decades, the function and responsibility of the physician has changed. It now often matters greatly whether the family practitioner, who is generally the first one to meet the medical problem, overlooks the underlying

*Presented at the 101st Annual Meeting of the Providence Medical Association, at Providence, R. I., January 5, 1948.

continued on next page

cause of the illness. He has the most difficult task, for he needs to guide the patient along the right path for further investigation. He must choose what test to perform or from what specialist to seek further guidance. His training may leave him bewildered, for he learned in his internship days that the possibilities involved in many cases are numerous. The early habits that he developed were those prevalent in intra-mural practice. Now he needs an entirely different point of view, one that is suitable to extra-mural practice.

During the years spent in hospital training, the young physician learns a good deal about an extensive differential diagnosis. An obscure case is admitted and quickly several possibilities come to his mind. Within a few days the Wassermann test is found to be negative which rules out syphilis. An X-ray of the chest is done and found to be normal, which eliminates tuberculosis and tumor of the lung. Various blood and urine examinations are performed, as a result of which leukemia, polycythemia, uremia, diabetes and other conditions can be dismissed. Finally, the blood culture report is returned, and found to be positive for streptococcus viridans and the diagnosis of sub-acute bacterial endocarditis is made. In fact, many of these tests are routine in most teaching hospitals so that the physician does not even have to think about these possible diagnoses. How different the situation is when you go into practice, especially in general practice! You can not turn around and ask what the blood counts were or what the X-ray of chest showed or what the lumbar puncture revealed. You only have your five senses and a few simple instruments that you carry in your bag. An entirely different type of thinking is now necessary. In some ways the early intra-mural or hospital training may actually be a handicap. There are many diagnoses that are automatically made or eliminated in hospital practice. The young interne or the senior staff member cannot overlook conditions like diabetes, leukemia, polycythemia and many others because the routine tests done the first day or two quickly supply data to answer these questions. The result is that one does not even have to think about many of these possibilities.

When the physician continues his work in extra-mural practice and is left on his own resources, he now has to think particularly of those conditions which his more restricted routine does not cover. He no longer performs a Wassermann test on every new patient or examines the fundi or counts the blood corpuscles. He now must choose which of an endless variety of examinations he should perform. He cannot do all of them, for much time and money would be wasted. After formulating a reasonable procedure for every new patient, which might well include a routine examination of the urine, a deter-

mination of the blood pressure, in addition to an adequate family history, past history, present illness and physical examination, the busy practitioner needs simple clues to guide him for further study or treatment. Additional study may not be necessary when the problem is simple. When an elderly patient is suddenly stricken with a hemiplegia and is found to have a blood pressure of 220/110, there is very little doubt but that he suffered a cerebral hemorrhage or thrombosis. However, if the same hemiplegia occurred in a young woman 35 years old, who had a blood pressure of 125/85, he would listen to the heart with greater care and possibly find evidence of mitral stenosis and conclude that cerebral embolism had occurred.

The great difficulty centers around those cases in which the preliminary survey fails to reveal an adequate diagnosis. The general practitioner has the most difficult task of all physicians. He must discover the one patient out of a thousand he sees who has a brain tumor, or pernicious anemia; the one in a hundred who has pulmonary tuberculosis; the rare case of coarctation of the aorta, as well as the more common patient with acute appendicitis, cancer of the bowel or streptococcus sore throat. It was not difficult for the late Dr. Harvey Cushing to make the diagnosis of brain tumor in most cases, for his patients were sent to him with that diagnosis already suspected. It was the function of that great master to confirm the diagnosis and perform the delicate task of curing the malady if it were possible. As was stated above, the really difficult job is for the physician in the field, so to speak, to find or suspect the case to begin with.

The following experience illustrates the change in the type of thinking required in general extra-mural practice from what often prevails within the confines of hospital practice. A woman sixty years old complained of some vague cerebral symptoms and had weakness of one arm. She was seen by two experienced consultants who did most of their work in teaching hospitals. Both agreed with the family physician that the patient was suffering from cerebral arteriosclerosis. By an odd chance I had an opportunity of seeing this case, and arrived at the same conclusion. However, I did suggest that there were several other possibilities that had not been ruled out by the limited examinations carried out in the patient's home. If she had been in a hospital, she would have had routine blood counts, a Wasserman test, X-ray of the skull and lumbar puncture. Some of the conditions upon which these procedures could throw light obviously had not been eliminated. I therefore advised searching for the possibility of luetic infection, brain tumor and polycythemia. As it turned out, the erythrocyte count proved to be 8.5 million and the diagnosis

of polycythemia vera was established. The point of this experience is that the correct diagnosis was made, not because I knew more than the other consultants about polycythemia. In fact, this was the first case I had recognized in private practice and this patient had been seen by a consultant who had written one of the best treatises on the subject. The difference was that the intra-mural physician never had to think about making the diagnosis of polycythemia. It was always made for him by the laboratory intern. Whereas I was aware of my limitations and realized that, in general practice, one had to think about those conditions that a very restricted routine examination did not include. We particularly need to think about those diseases which are amenable to medical or surgical treatment, and from which spontaneous recovery does not take place.

What is the physician to do when he sees his patient in the office or in the home? Which one of the innumerable tests should he employ? He cannot do all of them every time he sees a new patient. It would simplify matters greatly if the important ones could be as quickly and inexpensively performed as the Benedict test for sugar. Then we might well obtain a routine X-ray of the chest and gastro-intestinal tract, a complete blood examination, a metabolism determination, an electrocardiograph tracing, etc., in all cases. The diagnosis of diabetes is not often overlooked, or one might say should not often be overlooked, because the diagnostic test is so simple. But many conditions require more time and elaborate techniques for their analyses, and the physician needs some clue as to which he should perform. There are many such clues available, and the experienced clinician is constantly using this method consciously or subconsciously. After constructing an extensive differential diagnoses for a certain set of clinical circumstances, a process one learns particularly in hospital training, he now is confronted with the problem of eliminating one condition or another — or what might be called the "destructive differential diagnosis." In intra-mural practice, one possibility after another is eliminated by certain tests. In extra-mural practice the physician would like to perform the right test first or soon, as he fears he will not be able to perform them all. He needs simple bedside guides to enable him to dismiss some of the possible diagnosis from consideration, to spare the patient the trouble and expense of additional laboratory procedures. Instead of doing a Wasserman test that rules out syphilis, an X-ray that rules out tuberculosis, a blood culture that rules out bacterial endocarditis, and finally a basal metabolism determination that establishes the diagnosis of thyrotoxicosis, he would wish to perform that last test first.

There is great need, therefore, for simple means to rule out diagnoses as well as to rule them in. This entails the use of short cuts, which need not be absolutely accurate, but which enable the physician to be guided more quickly to the correct diagnosis. This method of medical thinking is sometimes frowned upon because it is not scientific, but I am certain that it is very helpful and useful, especially for the active, busy practitioner or consultant. All experienced physicians constantly employ this method, but very little is formally taught about it. Let me illustrate. Frequently the possibility of hyperthyroidism comes up when there has been loss of weight, weakness, shortness of breath, and some other vague signs or symptoms. We know that a basal metabolism test can answer the question. But if the patient prefers summer to winter and has a coarse dry skin, it is very unlikely that he has hyperthyroidism, and one would be justified in not performing the metabolism test at that time, and look for some other cause. On the other hand, if under the same circumstances, the patient preferred cold to warm weather and had a warm, moist skin, the metabolism determination might be the first test to do. In a very recent experience such simple bedside clues proved very decisive in a patient's recovery. This man had pain in the chest from coronary artery disease. The electrocardiograms definitely confirmed the diagnosis. He had been in bed for weeks with recurrent chest pain. When he was seen one cold morning (and his bedroom was also cold) he was covered with only one sheet and his feet were uncovered. When he was asked about this, he replied that for some years he had felt warm and did not like many bedclothes. That was enough to direct my attention at the thyroid gland. On careful palpation a small nodule was felt in one lobe, which had been overlooked and which one could readily miss unless it was deliberately looked for. He subsequently made a most gratifying recovery after a course of iodine therapy and a sub-total thyroidectomy.

Frequently in febrile illnesses the question of bacterial endocarditis and tuberculosis arises. One hundred years ago it did not matter whether the correct diagnosis was made. Now, with the availability of chemotherapeutic and other agents, it makes the difference between life and death. Here, also, a so-called short cut can be employed. If there has been prolonged fever, sweats and loss of weight and no murmurs whatever can be heard, blood cultures would be the last thing to obtain. Such a patient will almost never have bacterial endocarditis. By this simple bedside observation, one is justified in eliminating the diagnosis, and will more quickly look for tubercle bacilli in the sputum or gastric washings, or obtain an X-ray of the chest. In this way I have frequently been able to

continued on next page

rule out the diagnosis of subacute bacterial endocarditis (when it had been seriously entertained previously) even though I was unable to offer a more positive alternative diagnosis. There are many situations where it is vital at least to rule out a certain diagnosis, even if one cannot suggest the correct one. In the problem just discussed simple auscultation, which can be carried out by any physician in a few moments, may spare the patient the cost of several unnecessary blood cultures.

I have emphasized that the practitioner is mostly concerned with conditions that are amenable to treatment. In contrast, the investigator works on unsolved problems. As therapeutic procedures are discovered that are applicable to hitherto incurable conditions, the responsibility of the physician increases. A striking example of this is the surgical treatment of various forms of congenital heart disease. In the past it did not greatly matter what form of congenital defect was present, as there was no treatment available. Now that conditions like patent ductus arteriosus or coarctation of the aorta can be cured, it is imperative that correct diagnoses be made. Let us apply the principles discussed above to the new situation that confronts the general practitioner with regard to some of the problems of congenital heart disease. In order to discover cases of coarctation of the aorta, it is necessary to think of it in every patient with hypertension. As a further aid, it should become the routine habit for the physician to palpate the femoral arteries and abdominal aorta in every case of hypertension. If these pulsations appear normal and vigorous, one can fairly safely rule out coarctation of the aorta. If they are difficult to feel or entirely absent, the possibility of coarctation of the aorta is great, and then further tests need to be made to confirm the diagnosis, i.e., a lower blood pressure in the legs than in the arms, the presence of pulsating arteries near the scapulae, and notching of the ribs on X-ray examination. Inasmuch as it would be a great waste of time and effort to go through these additional procedures in all hypertensives, the simple bedside technique of finding adequate femoral pulsations limits this search to those who are most likely to have the condition under consideration. This is another instance in which a simple test can rule out a particular diagnosis, for the finding of a strong femoral pulse fairly well eliminates the possibility of coarctation of the aorta.

Angina pectoris is another example in which the diagnosis can generally be ruled out by simple means. All the physician needs to do is to ask one question. No expensive tests or elaborate methods of examination are necessary. If the patient can walk briskly in cold weather without stopping and without experiencing pain or distress in the chest,

one can be fairly certain that he is not suffering from angina. This does not apply to the diagnosis of coronary thrombosis, which often occurs at rest. Nor does the absence of chest distress on walking briskly eliminate the possibility of a previous attack of coronary thrombosis, for many patients have no physical limitations after such attacks. The point is that complete freedom in walking briskly, after meals, in cold weather and up grade, means that he has not angina at that time, and whatever symptoms such a patient might have are probably due to some other cause.

While considering angina pectoris and coronary artery disease, it is of interest to comment on the differences in the two sexes with relation to hypertension. Whereas angina is very common in men who never had hypertension, it is quite rare in non-hypertensive women, especially under the age of 55 to 60 years. If a woman has symptoms suggesting coronary artery disease and is known to have had a normal or low blood pressure all her life, it is well to look for some other cause. In such cases X-ray of the gall bladder looking for stones, of the spine for arthritis, of the gastro-intestinal tract for diaphragmatic hernia or other pathology, all are indicated and may reveal the true nature of the illness. Not long ago an obese woman 45 years old from this city came to see me. She had been in a hospital for several weeks and treated for acute coronary thrombosis. She had been taken with severe distress in the lower sternum and upper epigastrium, and during her hospital stay also developed heart block. The latter complication seemed to confirm the diagnosis. I learned that she never had hypertension and that the heart block followed liberal administration of digitalis. The absence of hypertension made me suspect that she did not have coronary artery disease, and X-ray examination showed a fairly large diaphragmatic hernia of the stomach. There was no evidence of heart disease, and subsequent events confirmed the fact that the stomach was the cause of her difficulty. One must admit that women do have coronary disease without hypertension, but it is comparatively rare. This general viewpoint merely directs attention to other possibilities that need investigation in certain cases that otherwise would be overlooked.

The appearance of the tongue is another simple clue that will aid the physician in diagnoses and help to eliminate certain possibilities. When a middled-aged or elderly patient is seen who is anemic, the possibility of pernicious anemia must always be considered. This condition must particularly be thought of because it is curable. If the tongue is dirty, coated and furrowed, one can readily dismiss pernicious anemia from mind. Contrariwise, if an anemic patient had been chronically

ill, possibly bedridden, and still shows a clean, smooth, somewhat glossy tongue that is likely to be less pale than the skin, the possibility of pernicious anemia is so great that all effort should be made to establish the diagnosis, e.g., gastric analysis, blood counts, etc. This simple observation of the tongue that only takes a few seconds has enabled me to make the diagnosis of primary anemia on several occasions, when patients were being unsuccessfully treated for chronic heart disease. In such cases the entire outlook would change and the patient would be completely rehabilitated, primarily as a result of observation of the tongue.

When the possibility of uremia comes up, there are also simple tests which any physician can perform that may help at least to rule out the diagnosis. If a patient is apathetic and drowsy and full-blooded, it is extremely unlikely that uremia is the cause. One does not see advanced chronic nephritis with uremia in a patient with a hemoglobin of 100%. This test can be performed readily, whereas the blood urea nitrogen determination is much more elaborate. Furthermore, the specific gravity of the urine may be very informing in such a case. If the specific gravity is 1020-25 or more, it is extremely unlikely that the patient has uremia. These again are so-called diagnostic short-cuts. They are helpful to "rule out" diagnoses even if they do not establish the correct diagnosis.

Nowadays we have to keep in mind rare conditions that are amenable to treatment or to cure. Amongst these is Addison's disease. As has been stated above, every therapeutic discovery brings a new challenge and responsibility to the physician. Previously Addison's disease was fatal; now it can be controlled and patients enabled to live long and useful lives. If this diagnosis comes up for consideration, the finding of even slight enlargement of the heart is a reliable sign that Addison's disease is not present. With adrenal insufficiency the heart is smaller than normal, not larger than normal. This does not mean that all patients with small hearts have Addison's disease, but it does mean that practically no patient with an enlarged heart has Addison's disease.

Physicians too often send patients to hospitals for diagnosis when simple examination in the office or the home should have been adequate. The diagnosis of angina pectoris in the great majority of cases can be made after an intelligent appraisal of the symptoms and little additional useful information will be acquired by elaborate hospital study. The same is true of the diagnosis of mitral stenosis. If, on careful auscultation, the diagnostic signs of mitral stenosis are detected, it will not help materially to know whether the heart is slightly or moderately enlarged or whether the electrocardiograms show right or left axis deviation. This does

not mean that there are not circumstances under which hospitalization may be profitable. There may be certain aspects of treatment, such as thoracentesis, that can better be carried out there. Additional diagnostic study may be indicated in certain cases, such as repeated blood cultures for a suspected bacterial endocarditis. However, the anatomical diagnosis of mitral stenosis, *per se*, rarely requires hospital study. It is mainly when there is doubt concerning the diagnosis that hospitalization is necessary. In this regard, the more intelligent use the physician makes of the simple methods of examination that require no more than what he carries in his head and in his bag, the less he will need the hospital.

The hospital is, therefore, needed when diagnosis is obscure and simple diagnostic procedures are inadequate. There various elaborate tests can be performed, and it taxes the wisdom of the physician to select those tests which are most likely to reveal the underlying cause or nature of the disease. A striking example of the usefulness of hospital study where the diagnosis was obscure is the following experience. Several years ago I saw a man about 20 years old who had been blue since birth. He had been regarded as having some form of congenital heart disease. I was unable to find any abnormalities of the heart on physical examination, and fluoroscopic and electrocardiographic examinations were also normal. Although he was markedly cyanotic, he did not have clubbing of the fingers. I sent him into the Peter Bent Brigham Hospital for study. There our resident physician (Dr. C. B. Favour) quickly withdrew some venous blood and bubbled oxygen through it. He observed that the blood remained blue instead of becoming red, as it normally should. From this he concluded that the case was one of congenital methemoglobinemia and not congenital heart disease. This diagnosis was subsequently confirmed by chemical and spectroscopic study. As a dramatic climax, within 30 minutes after giving this patient methylene blue, his color was normal for the first time in his life. This experience is recorded to illustrate the usefulness of hospitalization when the diagnosis is obscure.

The hospital is also needed to carry out certain care, medical or surgical, that cannot be performed adequately or at all at home. The need for hospitals has increased greatly in recent years, and is likely to continue to increase. With every new advance of technology, new methods of study and treatment become available. To mention congenital heart disease again, now that surgical treatment is available, more and more cases will have to be studied by catheterization of the heart. This is a very involved and elaborate, though riskless, procedure. It requires hours of work on the part of

continued on next page

many people, and yet it is indispensable for accurate diagnosis in some cases. This is merely one example to illustrate that the need for hospital space is increasing. It also illustrates why the cost of medical care will keep on increasing. There is more the physician can do to improve health. He now will want to go to a great deal of trouble to establish the diagnosis of patent ductus arteriosus, and then to have it cured surgically.

With each new therapeutic discovery we are compelled to look more diligently for those cases that might be helped by the new treatment. Until the present time, the diagnosis of cancer of the pancreas has been more a matter of academic interest than one of value to the patient. It may not be very distant when the situation will be changed. Attempts are being made at radical surgical cure of cancer of the pancreas. If this attains any real success, the diagnostic problems will increase tremendously, for it will then be necessary to investigate patients in hospitals very elaborately to detect early cases. This will obviously increase the need for hospital beds and the cost of medical care.

In this general discourse concerning extra and intra-mural practice which, as you see, has taken us into many fields, there are some useful habits or mental attitudes that are worth discussing. It is best for physicians to develop these habits early in practice, for then they serve their useful purpose reflexly, so to speak, and are not forgotten. It is well for a physician, on leaving the bedside of any patient who is seriously sick or not progressing favorably, to keep asking himself, "What further might I do that would help therapeutically or diagnostically?" "What may I be overlooking?" These questions should keep recurring in his mind long after he has left that patient, while he is driving his motor car or while walking to the theatre. "Has that patient who is gasping for breath one or two liters of fluid in the chest that can be removed? Did the diuresis that was expected accumulate in the bladder?" I recall finding 1500 cc. of urine in the bladder postmortem in such a patient I treated. It would have been a simple matter to catheterize this particular unconscious patient, and he might have been helped, had I not overlooked the full bladder.

It is important to think constantly of those conditions, even if rare, that are curable. I recall an early case of so-called arthritis of the spine which had disabled a particular man for 18 months. X-ray examination even showed some arthritic changes in the upper dorsal region. Only later did a more astute observer perform a lumbar puncture and establish the diagnosis of cord tumor. This proved to be an enucleable tumor, as they often are in the spinal cord, and the patient was completely cured. This costly experience proved valuable to

me in later years, as it enabled me to detect similar cases that I am sure I would otherwise have overlooked. The inference from such experiences is that it is more important to think of rare diseases that are curable and that do not spontaneously disappear, than the more common ones that are not curable or which do well with symptomatic treatment.

There are particular diagnoses which not infrequently are incorrect. A good example of this is multiple sclerosis. I have seen two instances in which competent neurologists made the diagnosis of multiple sclerosis, where subsequent study revealed a curable cord tumor. The same eventual diagnosis was made in isolated cases incorrectly diagnosed amyotrophic lateral sclerosis and combined system disease. It is well to rule out the possibility of cord tumor by any reasonable means in any disabling neurological condition affecting the spine, if there is no definite involvement of the brain or cranial nerves. Obviously, if the brain is involved as well as the spinal cord, the diagnosis cannot be cord tumor, and must be a more general and widespread lesion. I mention these neurological conditions, although they are somewhat beyond my common interest, because I have had the opportunity of making such correct diagnoses of spinal cord tumor when neurologists have been wrong. It was not because I was more familiar with the problems of neurology that I reached the correct diagnosis. It was rather because I knew less of neurology, but realized my limitations and was more concerned with the general principle of looking for curable disease than were my neurological colleagues.

There is another habit of mind or mode of thinking which physicians will find useful. There are combinations of symptoms or signs that often go together. Mitral stenosis, auricular fibrillation and a past history of rheumatic fever often are found in the same individual. If you find two of this triad, look for the third. If a patient with a past history of rheumatic fever later is found to have auricular fibrillation, he very likely has mitral stenosis, whether you can hear the diastolic murmur or not. Likewise, if a rheumatic with mitral stenosis develops an apparently very irregular rhythm, it is most likely auricular fibrillation. Another combination is gallop rhythm, bundle branch block and pulsus alternans. If two of the triad are present, it is well to look for the third. Similarly the triad of renal stones, limb pains and parathyroid adenoma may be helpful to enable the physicians to think about these rare but curable cases of tumor of the parathyroid. Also diabetics at the age of 50 to 60 years so frequently have coronary artery disease and gall stones that this combination of conditions should be kept in mind.

continued on page 371

MEDICAL LEADERSHIP*

ARTHUR H. RUGGLES, M.D.

The Author. Arthur H. Ruggles, M.D., of Providence. President, 1947-48, The Rhode Island Medical Society; Chairman, National Committee on Mental Hygiene; Past President, American Psychiatric Association, and the Council of the New England State Medical Societies; Former Superintendent, Butler Hospital, Providence.

LAST YEAR Dr. Pitts, your retiring president, in his address set an excellent example of brevity and wisdom. I shall follow his example in brevity and only wish I might approach his wisdom.

The whole world seems to be in an unsettled and apprehensive state. As physicians we surely are in a position to help not only sick bodies but sick and uncertain minds. Even in our own profession we have seen reverberation of the world's uncertainty and tension. The medical profession for a long period of time has been so busy and so absorbed in its own mission of trying to prevent disease, and its duties in the care of the sick, and in its ever continuing research studies, that we have had very little time to devote to the broad social, economic and spiritual problems of our communities. To me it is very remarkable that so many busy physicians have been able to contribute as much as they have in their efforts in community betterment and many other types of public service. More especially in recent years the sum total of medical knowledge has steadily increased. The demands made upon the general practitioner and more particularly the specialist are constantly increased. Like all professions, in fact as in all walks of life, we cannot stand still, we must either go ahead or slip back. Thus the demands upon our time constantly increase, and yet there are still only twenty-four hours in every day.

We have recently heard some criticism that on certain days and evenings of the week the average citizen has found it difficult to obtain medical services. Your Society has given heed to complaints of citizens, even though often upon investigation the complaints have been quite unfair and over-demanding. We have always wanted in Rhode Island, to give the very best possible professional

service to all who need it, but again let me remind you that all work and no play would make the doctor a dull fellow, and as we look about us it is a rare doctor who works only forty-eight hours a week, while the rest of the world tries to impress us with the fact that they would be better off if they only worked forty.

In addition to performing their own daily tasks well, many members of our Society have, during the year, made very definite contributions in their efforts to lessen and prevent water and air pollution and we have made some worthwhile gains in this direction.

Our many committees have taken much time out from busy practices in order to carry out their committee responsibility in a variety of fields, especially our health plan insurance study committee, which for over a year now has devoted many hours of thinking, conferring and planning toward a pre-paid insurance plan that will protect those in lower income brackets in meeting operative fees, which have been set by your Society, when surgery becomes necessary. The work of this committee has already led to pre-paid surgical insurance being offered to many of our citizens at reasonable rates, and in doing this, members of your profession have been willing to accept extremely low fees. For the work and sacrifice of the members of our profession, the people of Rhode Island should be very grateful. I only wish that the Blue Cross might participate in this plan, so that competition would be wide open and that our citizens be offered a premium schedule based on the widest of competition. The success of the surgical plan has not yet been brilliant, but we are told by those of experience that a good deal of education must precede the wide-spread demand for such insurance, and that we must wait another six months before the full benefit of the present plan can be estimated. Now within the past few weeks a meeting of the representatives of the Associated Medical Care Plans Association, together with the Directors of Blue Cross Commissions and Directors and Trustees of American Hospital Plans, was held, and discussed a proposed merger of the AMCP and Blue Cross, and the development of a national insurance company. A meeting has been called for June 19th, at the headquarters of the American Medical Association, regarding this whole subject.

continued on next page

*Presidential Address Delivered before the Rhode Island Medical Society at its 137th Annual Meeting, at Providence, May 13, 1948.

As those members of the Society who have been in close touch with the surgical insurance plan realize, this is a very large, complicated and difficult problem to solve and will need long and careful thinking through if a strong, practical plan is to result.

Again this is a recent illustration of the need for medical leadership in the whole problem of the practice of medicine, as well as in the solution of medical economic problems.

We have discussed during the year the formation of a Rhode Island Health Council, which should build health planning on a state-wide basis in order that one part of our State might benefit by what has been learned in another area and so that we might form our plans on a mutually cooperative basis. It has been the thought of those interested in a Rhode Island Health Council, that such problems as tuberculosis, cancer, poliomyelitis, mental illness, the care of the aged sick, might be studied in rural and urban areas; that the provisions for the care of those illnesses needing to be hospitalized could be determined; the question of outpatient facilities studied and recommendations made on the basis of adequate health facilities, both public and private, for every resident in our State.

The recent failure to pass the bill for improved standards of medical examiners' service perhaps illustrates what a strong state-wide health council could have done in bringing pressure to bear upon the Legislature for modernizing a somewhat antiquated medical examiner system.

Members of the medical profession and those interested in health problems from the various social angles have met, and a committee appointed by your President is further studying the organization of a state-wide health council, which I sincerely hope may eventuate.

The Governor of our State has appointed a Hospital Advisory Commission to study and coordinate the hospital facilities of Rhode Island, with a view toward establishing priorities that would make federal funds available for new construction, and on this Commission there are three members of this Society. This Commission is given the responsibility of determining what added hospital facilities are needed in the State; what areas in the State are most efficient in hospital bed facilities; whether an increasing or decreasing number of beds is needed for different types of disease, and seeing to it that federal funds are not allocated unless such hospital construction is definitely needed, and upon the recommendation of such conditions, new hospital construction can come into being and the Federal Government will match every two local dollars with one dollar, toward such hospital construction. These indicated developments in our State are all evidence for need for coordinated

planning, for plan financing and for seeing all the health needs of the State from a long-range point of view. The days of hit or miss study in the field of health are being replaced by state-wide studies, planning and development. In this the members of your Society will constantly be called upon for their leadership. It has recently been said by Dr. Edward L. Bortz, President of the American Medical Association, that, "leadership in human relationships concerned with health and the control of disease, should come from the medical profession", and with this statement I am sure all members of the Rhode Island medical profession are in the heartiest of agreement.

It has been my privilege during the year to act as President of the Council of New England State Medical Societies, which has brought together officers and official representatives of the medical societies of all the New England states. One of these meetings was devoted to the extremely important topic of public relations. I think all the physicians in this group feel that such a Council set-up on a New England basis has been very valuable in the sharing of the many problems that are coming to the medical profession in these days of rapidly evolving social and medical change.

We also need to utilize our thinking and our influence in improving conditions in food handling and in promoting better laws and the enforcement of those laws for improved standards of milk. We need more time, personnel and opportunity for research problems in the fields of cancer, tuberculosis, mental illness and the diseases of old age.

Never has there been a time in the lives of any of us here present that has called for more careful thinking through of our problems and wise and constructive planning. The members of the medical profession have shown their willingness to give leadership, but must continue to do this in increasing amounts, which often presents real financial problems to the physician who has to give up so much time from practice in attending the necessary committee meetings, and yet I urge upon you that you take the necessary time to engage in the deliberations of our own Society and take a part in the organized committee work of the District and State Society.

We have during the year sent out a questionnaire to all our members, in order to determine whether they had time for committee assignments and on what committees they would like to serve. In this way we have found a number of doctors eager and able to serve on committees whom we had not been utilizing to the fullest extent. We hope if the load is widely spread, more interest in our Society's activities will be created and no one should be over-burdened with committee assignments.

Either the medical profession is going to continue to play the leading role in the development of better health for all our citizens, or else we have the ever-present threat of its being taken over by extremely well-meaning, often well-informed, but not medically trained individuals. We are members of an old and noble profession who have always risen to community or world needs whether in peace or in war, and I am sure that at this important time in the world's history we will not be found wanting. Through such leadership the advances in obstetrics, pediatrics, psychiatry, medicine and surgery, especially in neurosurgery, have been very great. In fact I know of no decade in history that has produced more beneficial knowledge to be applied to the prevention and cure of illness. Our citizens are living longer. The expectancy of life is steadily being prolonged and this has necessarily caused a tremendous problem in the care of aged people. Geriatrics has been thrust upon us and has already produced a magazine, various books and local and national organizations. Our profession must give thought to the physical and mental welfare of those who have reached the retirement age, and yet who have never learned to play. We must give further study to the deteriorating diseases and their prevention and treatment. Perhaps modern prostatectomy is one of the best illustrations of what advances can be made in the alleviation of deteriorating diseases and some of us are gradually learning that medical science has the relief for many other deteriorating diseases which, unaided, may lead to senile deterioration. For example: the restoration of eyesight by the removal of cataracts; the benefits obtained by hearing aids; the surgical cure of hernias; the support of the failing heart; proper diet and proper amounts of rest. These are just a few indications that very often so-called chronic conditions may not necessarily be entirely chronic. We must think through the problem of the cost of care of aged people and whether that is best arranged in connection with our special hospitals or in general hospitals, or by both means. We as a profession must see to it that if there is to be a new draft, with its consequent call upon many physicians, that such call be made in a carefully thought-out and planned manner, so that our medical schools, our hospitals and the care of the civilians is not interfered with too violently.

I have always enjoyed an expression of Wordsworth—"The shepherds stood on the hills guarding their flocks in calm contemplation." This is a time when we need more "calm contemplation" on the part of our profession toward the multitude of intricate and challenging problems that assail us on every side. At times it seems as if, perhaps, we

had been doing a good deal of wishful thinking, with a tendency to let George do it, but at the present time both in short-term planning and planning as far into the future as one can foresee, we shall need all the professional leadership that we can command, and that leadership must think through our problems, determine the facts regarding them and must base both present and future plans upon this thinking and this fact-finding. It is only with the help of all of you that medicine can maintain its honored tradition and advance its leadership.

EXTRA-MURAL AND INTRA-MURAL PRACTICE—THEN AND NOW

concluded from page 368

In a word, the responsibility of the physician is perfectly tremendous nowadays as compared to 100 years ago. There was very little that he could have done when this society was founded in 1848, either in extra-mural or intra-mural practice. Now it matters greatly whether a profound anemia is due to metastatic cancer of the bones or to pernicious anemia. One hundred years ago a patient was not neglected if abdominal swelling and ascites was thought to be due to cirrhosis of the liver, when in fact it resulted from pericardial constriction. Now very little can be done for the former, but the latter may be cured. Then a murmur due to rheumatic aortic valvular disease could be confused with one due to patent ductus arteriosus without jeopardizing the health of the patient, for neither condition could be treated effectively. Now one of the two conditions can be rectified. One could continue almost indefinitely and enumerate many diseases that are now amenable to medical or surgical treatment which formerly were beyond our reach. All this impels us to utilize the various methods of study that are available, and particularly the simple bedside techniques that we all have readily at hand. In this way we will continue to merit the confidence of our patients, who entrust their health, the most precious asset they possess, to our care.

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PROFOUND PRERENAL AZOTEMIA RESULTING FROM PYLORIC STENOSIS*

Report of a Case With Postoperative Followup

AARON T. BECK, M.D.

The Author. Aaron T. Beck, M.D., of Providence. Former Assistant Resident in Pathology, R. I. Hospital; now Assistant Resident in Neurology, Cushing General Hospital, Framingham, Massachusetts.

PRERENAL AZOTEMIA, a state of renal insufficiency resulting from disease outside of the urinary tract, has been described in a wide variety of conditions. It has been observed in cases of prolonged vomiting caused by intestinal obstruction or the pernicious vomiting of pregnancy; in cases of severe diarrhea, such as occurs in Cholera; in cases of duodenal fistula; in diabetic coma; in the crisis of Addison's Disease; and in shock due to a host of causes, such as trauma, acute blood loss, and myocardial infarction.

REPORT OF CASE

FIRST ADMISSION — 7/27/42-8/1/42. A 42-year-old, white, single female was admitted on July 27, 1942 to the Medical Service of the Rhode Island Hospital with a Chief Complaint of intermittent vomiting. The patient had felt perfectly well until four months prior to admission when she began to vomit small amounts of recently ingested food and to experience gaseous eructations. There were no other gastrointestinal symptoms. A gastrointestinal series in the Outpatient Department one month prior to admission was reported to have shown pyloric obstruction. The duodenum had not been visualized.

Physical examination on admission was negative. Urinalysis revealed: specific gravity 1.018; albumin negative; spun sediment 10 white blood cells. The blood urea nitrogen was 5 mg. per cent. Gastrointestinal series showed a moderate amount of fasting free fluid present in the stomach. The rest of the gastrointestinal tract was not described. The patient was asymptomatic during her hospital stay. The service felt that the vomiting might be psychic in origin. She was discharged, improved, on August 1, 1942. The discharge diagnosis was "Undiagnosed Disease."

SECOND ADMISSION — 10/25/45-11/14/45. The patient was readmitted to the Rhode Island

*Presented at a meeting of the Providence Medical Association, at Providence, March 1, 1948.

Hospital on October 25, 1945 because of convulsions. Following her previous discharge, she had been perfectly well except for occasional vomiting. Three months prior to this admission, however, her vomiting began to recur every night and became progressively worse. Three days prior to admission she began to vomit everything she ate. The day of admission she experienced two generalized convulsions.

Physical examination revealed a well-developed, well-nourished female in a stuporous state. She showed occasional periods of Cheyne-Stokes breathing. The blood pressure was 120/80. The reflexes were generally hypoactive. The fundi were negative. The blood urea nitrogen was 73 mg. per cent and creatinine 4.9 mg. per cent. Urinalysis showed: protein 2 plus; sugar negative; sediment 5-8 white blood cells and 15 granular casts.

The patient experienced another generalized convolution soon after her arrival on the ward. She appeared markedly dehydrated and was given 2000 c.c. of intravenous normal saline in the next twelve hours. A lumbar puncture showed a normal pressure, cell count and protein. Following intravenous fluids, the blood urea nitrogen dropped to 29 mg. per cent and the creatinine to 1.2 mg. Concomitantly she showed marked clinical improvement and became alert and rational. On November 2 hemoglobin was 13.7 gm.; white blood count 9,550 with a normal differential. Phenolsulfonphthalein test showed 65% excretion in two hours. Chest x-ray, barium enema and skull x-ray were negative. One week following admission the patient became asymptomatic and remained so during the rest of her hospital stay. It was felt on admission that this patient probably had an intracranial lesion in view of her convulsions, vomiting and coma. Laboratory tests and subsequent neurological examinations, however, failed to substantiate this. She was discharged on November 14, 1945 with the diagnosis of "gastric neurosis".

INTERVAL NOTE — 11/15/45-4/23/46. Following her discharge from the Rhode Island Hospital, the patient continued to vomit every night and became increasingly drowsy and finally comatose. On January 7, 1946 she was admitted to the State Hospital for Mental Diseases. A physical examination at that time disclosed the patient lying

motionless and staring fixedly ahead. She showed no awareness of her environment and did not respond to spoken voice or manipulation of her body. Her pupils were pin point and did not react to light. Her blood pressure was 100/60. She showed marked dehydration and muscle rigidity. She remained in a stuporous state for four days during which time she received 2000 c.c. of 5% dextrose in saline intravenously every day. She then began to show signs of mental clearing. Within a week she had become alert and completely oriented. Two weeks later she began to vomit and again lapsed into coma. The following day she had two convulsions. This time she remained in coma for nine days. The deep tendon reflexes were absent. A uremic frost was noted. She appeared moribund. The blood urea nitrogen was 299 mg. per cent; creatinine 6.6 mg. per cent; phosphorus 4.5 mg. per cent; and calcium 4.5 mg. per cent. She again received large quantities of intravenous fluids and regained alertness and orientation. One and one-half months later she once again lapsed into coma after an episode of vomiting. It was noted that each time she became comatose the blood urea nitro-

gen would increase. On April 21, 1946 transfer to the Rhode Island Hospital was advised by the medical consultant. The discharge diagnosis at the State Hospital for Mental Diseases was: (1) ? hysteria; (2) episodes of alkalosis and azotemia of unknown etiology.

THIRD ADMISSION — 4/24/46-6/26/46. The patient was readmitted to the Rhode Island Hospital on April 24, 1946. Physical examination showed a poorly-nourished, mute, uncooperative patient. The abdomen was distended and tympanic. There were bed sores on the buttocks and one plus edema of the extremities. The reflexes were equal and hyperactive. The patient weighed 80 lbs.

The urine on admission showed protein 3 plus; sugar 1 plus; no acetone; sediment 10-15 white blood cells, 1-2 red blood cells, a few granular casts; and a specific gravity of 1.010. The blood urea nitrogen was 146 mg. per cent; creatinine 11.2 mg. per cent; carbon dioxide combining power 137 volumes per cent; and sodium chloride 260 mg. per cent. Phenosulfonphthalein test on May 6 showed less than 5% excretion in two hours. Red blood

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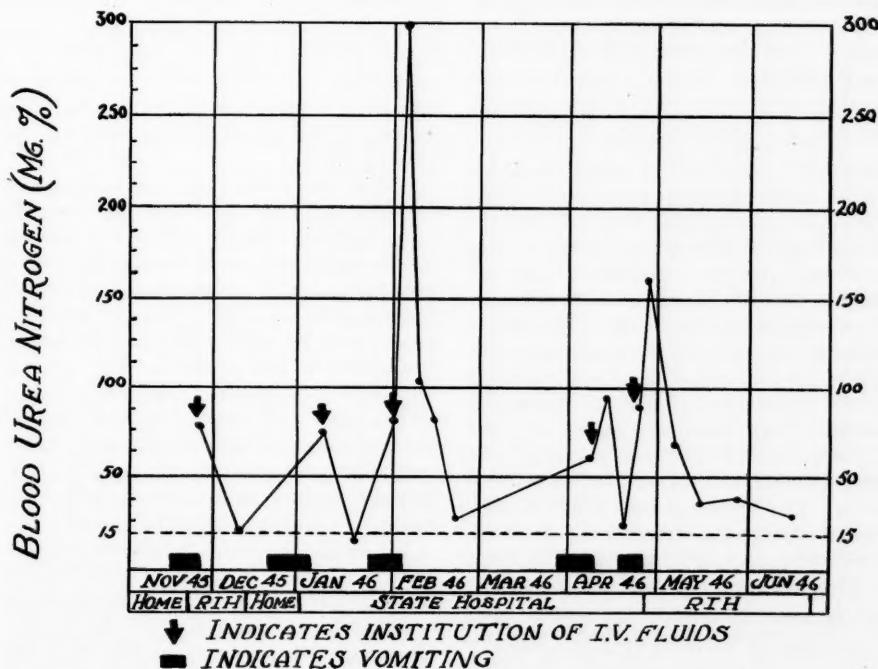


Figure 1. The relation of the blood urea nitrogen to episodes of vomiting and the response to the administration of intravenous saline.

count was 2,600,000; the white blood count was 10,500 with a normal differential.

It was felt that this patient's azotemia resulted from her vomiting and dehydration. She received large quantities of intravenous saline to correct her electrolyte imbalance. As soon as she was able to take fluids orally, she was given dilute hydrochloric acid and ammonium chloride by mouth. Later she was placed on a soft diet. However, aspiration of the gastric contents every night revealed a daily residue of at least 1000 c.c. Gastric analysis showed free hydrochloric acid. On May 27, 1946 blood urea nitrogen was 40 mg. per cent; creatinine 3.0 mg. per cent; and sodium chloride 495 mg. per cent. Study of this patient's family background revealed a long history of maternal domination. It was felt, however, that she had an organic lesion and as soon as she could retain a barium meal a gastrointestinal series was performed. This disclosed a tremendously dilated stomach. The duodenum did not fill with barium. The impression was pyloric obstruction probably due to ulcer. The patient received five transfusions of whole blood and on her 51st day in the hospital a subtotal gastrectomy was performed. At operation, the duodenum was found to be greatly narrowed and fibrosed in its proximal portion. A scarred ulcer was noted in the region of the pyloris. In the pathological report, edema and stenosis of the pylorus were described. Microscopic diagnosis was chronic gastritis and duodenitis. The postoperative course was uneventful and there was no further vomiting. The patient was discharged on June 26, 1946.

FOLLOW-UP NOTE—The patient was seen in the Outpatient Department on August 9, 1946 and reported a 30 lb. weight gain in the two months following discharge. The blood urea nitrogen at this time was 35 mg. per cent; creatinine 2.5 mg. per cent and sodium chloride 522 mg. per cent. The patient was seen again on December 26, 1946 and reported continued improvement. She was now working full time at her former job. Blood studies at this time showed a blood urea nitrogen of 30 mg. per cent; creatinine 2.0 mg. per cent; protein 6.5 gm. per cent; and sodium chloride 510 mg. per cent. The phenolsulfonphthalein test showed 35% excretion in two hours. The Fishberg urine concentration test showed a maximum specific gravity of 1.016. The urea clearance was 40% of normal standard clearance. On December 20, 1947, the patient was seen again and appeared robust. She now weighed 150 lbs. She reported no recurrence of nausea or vomiting in the one and one-half years since her operation. At this examination the blood urea nitrogen was 19 mg. per cent; creatinine 1.9 mg. per cent; and the phenolsulfonphthalein test 45% excretion in two hours. The urine concentration

RHODE ISLAND MEDICAL JOURNAL

test showed a maximum specific gravity of 1.018 and the urea clearance was 59% of normal.

	PSP Test	Urine Conc. Test Maximum S.G.	Urea Clearance
11-15-45	65%
4-17-46	22%	1.028
5-16-46	5%	1.008
12-26-46	35%	1.016	40%
12-20-47	45%	1.018	59%

Table 1. Kidney function tests during various stages of the disease.

DISCUSSION—This case presents several features that warrant comment: 1. The episodes of convulsions, coma, and uremia always followed prolonged vomiting and were terminated by the administration of adequate fluid and electrolyte. The mechanism by which the vomiting led to the clinical picture of uremia, appears to have been as follows: The loss of water and hydrochloric acid by vomiting produced severe dehydration, hypochloremia, and alkalosis. The dehydration resulted in decreased blood flow through the kidneys and, consequently, impairment of renal function. The hypochloremia and alkalosis further contributed to the development of renal insufficiency and uremia. When the normal renal blood flow and normal electrolyte balance of the blood were restored by the intravenous administration of saline solution, the kidney function improved and the blood urea nitrogen dropped. At the same time, there was a corresponding clinical improvement. Since this patient gave no evidence of any primary disease of the kidney, this case fulfills the criteria of "prerenal azotemia".

2. The real nature of the patient's illness was not clarified until four years after her first admission to the hospital. During this period, she was moribund several times and it appears probable that she would have died if she had not received intravenous fluids in time. The diagnoses entertained at various times included brain tumor, gastric neurosis, schizophrenia, and hysteria. The real cause of the vomiting was finally established to be pyloric obstruction on the basis of a peptic ulcer. A curious feature is the fact that she never experienced pain. Once the obstruction was relieved by operation she made a rapid recovery and was able to return to a normal, productive life.

3. The blood chemistry values in this case were quite unusual. The carbon dioxide combining power of 137 volumes per cent was the highest ever reported by the laboratory of the Rhode Island Hospital. Other extremely abnormal values include the blood sodium chloride of 220 mg. per cent; the calcium of 4.5 mg. per cent and the phosphorus of 4.5 mg. per cent; the blood urea nitrogen of 299 mg. per cent; and the creatinine of 13 mg. per cent.

continued on page 377

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NAVY POLLUTION IN NARRAGANSETT BAY

FOR A YEAR or so we have had nothing to say about Water Pollution. Just previous to this the medical profession of the state had a good deal to do with stirring up interest in this matter which had been lying dormant during the war. The problem was forced into politics with the result that the Blackstone Valley Sewer Commission project is well under way and a bond issue has just been approved for the sewage disposal plant at Fields Point.

The Pollution Abatement Committee of Rhode Island has been formed and is decidedly active. It consists of members from many organizations, including two members of the Rhode Island Medical Society's Committee. Most of the cities and towns bordering on the water have been stirred into activity. Already \$10,000,000 has been voted to improve old plants or construct new ones.

The State committee also reports that the oil situation has greatly improved and the oil companies are cooperating. This last is particularly pleasing to report for all the rosy prospects we have been painting are futuristic. We use this word in the theological sense of fulfillment in the future and not in the art sense which seems to many of us to bear no resemblance to reality.

Last year we were bearing down hard on Pawtucket. Now we are told that Providence is running much infected sewage into the Bay and is even carrying great amounts down the Bay and dumping them where otherwise the water did have some chance of being clean.

A few years ago there was considerable excitement about the state over the report that the Navy was going to move from Narragansett Bay. Well, we would have decidedly cleaner water if they did. The Navy has been a bad offender not only from its ships which of course are in an awkward predicament when lying in port but also from its shore installations which of course can easily install disposal plants.

The Navy has certainly thrown money around freely for its programs. But when decency demands that they take care of their human sewage they become as parsimonious as any New England deacon or Quaker elder. Admiral Cooley has been quoted in the paper as saying the Navy would install proper disposal plants when nearby towns did and he has been commended editorially by our local paper for his graciousness. We see nothing to commend when the richest organization in the world violates decency on the plea that some little

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poverty stricken town hasn't done all it should. We thought one of the proudest boasts of our armed services and one of the outstanding reasons for our success in the last war was their hygienic record. It is shocking to know of their sewer pipes discharging into our Bay.

The Pollution Committee has been in correspondence with our senior senator and he has communicated with the Navy. The replies he has received, after the supernatant pleasant words have drained off leave this residue: "The Naval Base has recognized the fact that the matter of pollution of Narragansett Bay from Naval shore establishments in the Newport area as well as from the

nearby communities is a serious problem," and this regarding what they are doing about it—"I am afraid that I cannot place the Navy Department on record as desiring that you undertake to have the necessary sum added to the 1948 appropriations for public works construction.

(signed) JOHN NICHOLAS BROWN

Acting Secretary of the Navy."

It must be unpleasant for our fellow citizen, with a home in Newport and a love for yachting to tell us that we must continue to wallow in the Navy's filth.

WHAT'S WRONG WITH THE PROFIT MOTIVE?

AT THE CLEVELAND session of the American Medical Association last January the Council on Medical Service reported that the insurance industry of this country has insured an estimated 44 million persons under health and accident coverage. The Council informs us further that it has established for itself a policy to require a one year period of operation of plans underwritten by private insurance carriers before such plans can have the seal of acceptance of the AMA. Yet a non-profit plan does not have to meet such a requirement. Thus a new organization with no experience is considered more acceptable than the Metropolitan Life Insurance Company which is participating in the Rhode Island Plan.

The insurance industry has a profit motive! This criticism, the major one leveled at the type of plan sponsored by our Society in its effort to lessen the cost of medical care for the individual, prompts us to pose the question of "What's wrong with the profit motive?" Is there any stronger motive by which this country can continue to provide the highest standard of living anywhere in the world today? Does anyone really believe that the standards we have built by competitive methods can be continued and improved by non-profit organizations?

The non-profit hospitalization plans have been a tremendous benefit, but their greatest boon has not been, to our way of thinking, the mere payment of hospital expenses, but rather the education of the public generally to the necessity for budgeting for a health need. The hospital bed now competes on an even basis with the radio, the mechanical ice box, and other necessities or luxuries for a share of the worker's pay.

Too much emphasis has been placed on the non-profit feature of the hospitalization and medical

care plans, and the public has been left with the impression that the insurance industry is concerned only with the profits it may realize from its business. Yet of the seven largest companies active in group health insurance, five are mutual companies which cannot, under the law, make a profit!

One very successful nonprofit hospitalization plan (Blue Cross) shows that over a five year period it paid out of the subscriber's dollar \$.69 in benefits, approximately \$.09 in expenses, and carried the \$.22 balance to surplus. Bearing in mind that no dividends to subscribers were paid, and that by reason of the contracts with institutions whereby service is guaranteed (thus freeing the plan of the imposition of public taxes as imposed on other insurance groups) it is easy to see that no major insurance company could duplicate the profitability of this operation. But had this non-profit plan charged adequate but not redundant rates it would have had a loss and expense ratio not far out of line with commercial companies.

As non-profit community institutions hospitals have from the beginning of the Blue Cross program insisted on non-profit sponsorship of hospitalization plans. That insistence, incorporated in the essentials set forth by the American Hospital Association in 1933, served to close the door to the insurance industry to participate equally in extending the scope of hospital insurance. The public was thus sold the idea that the only way for low cost insurance was by a non-profit community organization.

The medical care plans have followed a similar pattern. As a result, a program such as evolved by the Rhode Island Medical Society is excluded from the American Medical Care Plans organization because it is not exclusively non-profit. Likewise,

as noted above, the Council on Medical Service has been persuaded to throw up a barrier against the insurance industry that borders on the ridiculous.

Today, in the face of rising hospitals costs, the non-profit plans are finding themselves in the same yard as other insurance groups. Large surplus funds have been dipped into heavily, and the non-profit programs, without the sound actuarial experience of other insurance groups, have raised their premiums—as much as 35% here in Rhode Island where the enrollment is the highest in the country and where a tremendous reserve fund already existed.

We here in Rhode Island have no axe to grind for the insurance industry. We have set out to find a way to extend surgical care on a prepaid voluntary basis to as many persons as possible, and at the lowest practicable cost. We want everyone who has a good insurance policy to sell—one that meets the requirements set forth by the Society—to enter the competition here. But we want that competition on a fair basis, and always to the advantage of the people who will purchase the insurance.

Let's look at the latest classic in misrepresentation of the profit versus the non-profit program.

In March, 1947, the American Medical Association completed arrangements for a program providing hospital, surgical and in-hospital medical care benefits for employees of the Association. Hospitalization was with the Blue Cross of Chicago, and the surgical and in-hospital medical care program was underwritten by the Metropolitan Casualty Insurance Company of New York, as there was not in existence any medical society-sponsored surgical plan operating in Chicago or Illinois.

What happened?

During the year the Blue Cross raised the premium cost to the extent of some \$1,600. And when time came for the renewal of the contract this past March no assurance was given by Blue Cross that it wouldn't raise its rates during the ensuing 12-month period. (Insurance companies cannot raise their rates during a benefit year as the Blue Cross does). The general manager of the AMA, Dr. George Lull, sought contracts from insurance companies, and reportedly submitted them to the Board of Trustees. Subsequently a contract was purchased from the Continental Casualty Company in Chicago to cover both the hospitalization and the surgical-medical care.

What happened then?

"The AMA is adding support to the proponents of a national compulsory system." "The AMA is repudiating the principle of non-government, non-

profit, voluntary medically supervised hospitalization." "The AMA has 'sold out' to insurance interests. Etc., Etc." Such was the gist of the flood of medical society editorials, communications and resolutions from misinformed physician-editors, non-profit plans and medical associations. Resolutions are reported to be in preparation for the AMA House of Delegates this month asking that the action of the AMA in insuring its employees with a profit making plan be rescinded.

What is the true story?

The Chicago prepaid non-profit surgical plan was not selling policies at the time of the AMA contract renewal, and therefore no local non-profit plan was available. Also, the Illinois Medical Society is developing a plan similar to that in Rhode Island utilizing the insurance industry.

Therefore the issue centered around the program offered by the non-profit hospitalization organization which nationwide claims it wants competition from the insurance industry.

But, by purchasing the contract from the PROFIT making company the AMA will pay a reported \$2,277 LESS annually than it would have to pay the non-profit plan for contracts not offering as substantial benefits!

What's wrong with the profit motive, then? It is an honorable motive. Abuses in the form of excessive profits can be prevented. In effecting such preventive measures there is no need to destroy the system by the substitution of monopolies or non-profit programs, any more than there is need to regiment the entire medical profession to improve the medical care in certain areas of the country, or among certain groups of people in all sections.

PROFOUND PRERENAL AZOTEMIA RESULTING FROM PYLORIC STENOSIS

concluded from page 374

4. Another noteworthy feature was the residual renal insufficiency. One and one-half years following operation, the patient still showed abnormal values for the urine concentration test, the phenol-sulfonphthalein test, and the urea clearance. It may be speculated that irreversible changes have occurred in glomeruli and tubules as a result of the profound chemical derangement of the blood.

SUMMARY—(1) A case of profound prerenal azotemia, resulting from vomiting, in a 45-year-old female is presented.

(2) Following a subtotal gastrectomy for stenosing duodenal ulcer the patient made a remarkable clinical recovery.

(3) One and one-half years following operation there were still signs of residual renal impairment.

**REPORT OF THE HEALTH INSURANCE COMMITTEE
TO THE HOUSE OF DELEGATES OF THE RHODE ISLAND MEDICAL SOCIETY
MAY 5, 1948**

THE DEVELOPMENT of the Rhode Island Plan, the prepaid voluntary non-occupational surgical-obstetrical insurance program of the Rhode Island Medical Society, has necessarily developed slowly in the past four months.

Several important factors are called to your attention.

The Society had as its major motive the development of a program that would materially aid the person in the low-income group. All its planning was in that direction, with the understanding that aid to persons in such a category was of major concern. Hence a service provision was accepted by the Society to provide complete benefits to persons within specified income levels.

Much public discussion has centered on the service feature of the program. That is natural in view of the complete indemnity offered by it. But no one should lose sight of the fact that the program offers a definite contribution for every insured person, for the indemnity benefits compare most favorably with the best insurance plans in the country, and these same benefits are not available at similar cost in any other insurance contract. For every person, regardless of his income, the plan offers many attractive features.

This voluntary action of the medical profession is duplicated by no other professional or non-professional group of individuals.

Yet our Plan has been subject to disapproval by the officers of an organized labor group, and it has not been supported fairly by the daily press, because it does not embrace a larger section of the population who earn incomes that definitely remove them for what is generally understood across the nation as 'low income'. We are not unduly concerned by such reactions. We see in them a misunderstanding, a failure to appreciate our motives.

We have been challenged because our progress has been slow. But little recognition has been given to the fact that we are pioneering in a plan that may well set a pattern across the nation. Other state medical societies are now proposing plans very similar to ours, and all are looking towards our development for experience and technical advice. Among the state medical societies in this group are Maine, Wisconsin, Illinois, and Tennessee.

Thus it is apparent that what we do here will have a profound effect upon the planning for social security nationally. Our critics will do well to look to the state cash sickness compensation program which has been subject to criticism through the years because it was not adequately planned, and to a non-profit hospitalization plan in a neighboring state that sustained severe setbacks because of the introduction of contracts that were not practical in operation.

Actually a tremendous amount of work has been carried forward by your committee. Several conferences have been held with insurance representatives, and many technical issues relative to the policies submitted have been clarified. For example, final approval of several policies was held up pending a clear understanding by the insurance company of the Society's intention to cover injuries not compensable under the workmen's compensation law.

We have studied various claim forms, seeking to find a suitable one to be standard for all policies under the plan. We have prepared a direction to pay and physicians agreement form that we hope will simplify that important phase of the program; and we have given careful consideration to action to be followed relative to unlisted procedures, and to complaints that may arise in the handling of claims. The roster of participating physicians has been compiled, numbering at present 553, and a listing by cities and towns has been prepared for use by insurance companies and the public generally.

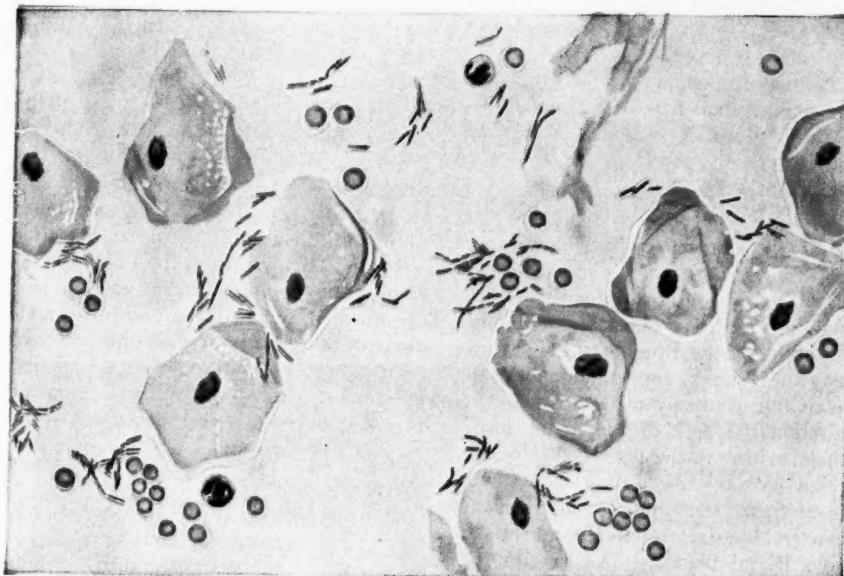
We have the assurance from the Truesdale Hospital staff of Fall River, Massachusetts, that it will accept the provisions of our plan when rendering treatment of any insured under it who may be hospitalized there. We have considered the possibility of making the suggestion to the staffs of hospitals in other communities bordering on Rhode Island that they consider the adoption of the same attitude as the Fall River group.

We have completed a question and answer summary that will be published in the RHODE ISLAND MEDICAL JOURNAL, and which we hope to make available in brochure form for statewide public distribution.

continued on page 380

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REPORT OF HEALTH INSURANCE COMMITTEE
continued from page 378

We have been encouraged by the response of the insurance companies. As they have become familiar with the details of the proposed plan they have now submitted policies, and at present we have received policies from thirteen companies, most of which have been approved. The companies are:

- Aetna Life Insurance of Hartford
- American Mutual Liability of Boston
- Connecticut General Life of Hartford
- Continental Casualty of Chicago
- Employers Mutual Liability of Wisconsin
- Equitable Assurance of New York
- John Hancock Mutual Life of Boston
- Liberty Mutual of Boston
- Massachusetts Mutual Life of Springfield
- Metropolitan Life of New York
- Monarch Life of Springfield
- Travelers of Hartford
- Washington National of Chicago

Other companies have expressed an interest in the plan, and have given assurance that they will participate as soon as it is possible for them to do so. Yesterday members of our Committee met with representatives of the Prudential Life Insurance Company of Newark, and we anticipate the participation of that company in the near future.

These represent the bulk of the major insurance companies writing in the health and accident field. Once they have organized their sales forces, have developed their promotional programs, and have stimulated public interest in the advantages of the Rhode Island plan we feel certain that there will be support from industry, labor, and the public in general.

Policies for sale will at first be restricted to groups. But we are informed that three, at least, of the companies will accept enrollment as low as groups of five. This presents a coverage for the small industrial establishments, office groups, etc., and we believe that no medical society sponsored plan in the country has as yet started on such a favorable basis.

When the Society announced its plan it provided that it should be under no obligation whatsoever to review the premium rate or rates of those policies submitted for its approval, since it is the desire of the Society to permit such rates to seek their natural levels through competition.

However, your Committee has naturally been interested in the premium rates to be charged for policies under the plan. We have viewed the rates submitted by some of the companies and we are encouraged that by competition there will be a variance that augurs well for the sale of policies. Cognizant of the sizeable female employment in

RHODE ISLAND MEDICAL JOURNAL

Rhode Island, some companies have found it advisable to have their minimum monthly rate increased for exposure on eligible female employees; other companies have decided on a flat rate regardless of the female worker population.

For example, the average minimum monthly premium rate of several policies viewed is 54c for the employee, and it is scaled upward for female coverage, since obstetrical benefits are provided, so that the rate would be 85c where 55% of the employees are females. For dependents the monthly flat rate, including obstetrical benefits for wives, is about \$1.75, and for families from \$2.50, ranging up or down according to whether obstetrical coverage is elected as immediate or waived for a nine month waiting period.

This range in premiums, scaled according to benefits desired, will result in some of the policies offering additional features of value to the insured. We interpret this as a healthy situation in a country where competition is allowed to exist and flourish to the advantage of the purchasing public.

In the public press there has appeared on one occasion a comparison of the rates of one company whose policy was approved by your Committee with the rates of some of the non-profit medical care plans in other parts of the country. Such a comparison on the actual premium charge alone without any consideration of the provisions of the different policies involved is most misleading and warrants criticism.

Consider these differences:

There is a variance in indemnity schedules in the different plans, and undoubtedly many do not benefit the insured to the extent that the Rhode Island Plan does.

Many non-profit plans do not include surgical services when rendered outside a hospital. The Rhode Island Plan does.

Many non-profit plans have lower income limits than those of the Rhode Island Plan, thus not providing as attractive a service feature. Some plans do not even include the service feature.

Most non-profit plans impose a waiting period for obstetrical coverage. There is provision for immediate coverage for enrolling groups under the Rhode Island Plan.

Waiting periods, besides for maternity, are imposed by most non-profit plans for certain surgical procedures, such as tonsil and adenoid operations, hernia, hemorrhoids, etc. Such waiting periods are not included under the Rhode Island Plan.

* * *

These examples indicate clearly the fallacy of comparing plans merely on the basis of the pre-

continued on page 386

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2. Before you telephone your doctor, make a list of the questions you want to ask him. Have a paper and a pencil handy when you call, so that you may take down his instructions. This way you will save your doctor's time, and remember accurately what he tells you.
3. Answer your doctor's questions fully. A previous illness may not seem to you to have any bearing on your present condition. But to your doctor it might furnish a valuable clue. Tell him complete facts. Let him decide what is important.
4. Follow your doctor's instructions exactly. If he prescribes medicine, take it according to directions. Remember, a larger dose than that prescribed won't cure you faster. And it might be harmful.
5. Never use medicine prescribed for somebody else, or for a previous illness of your own. However similar your symptoms may appear to you, the nature of your illness may be quite different. Only your doctor can accurately diagnose your trouble and prescribe proper treatment.
6. If your doctor advises an operation, don't put it off. With modern surgery, modern hospital care, you seldom have reason to fear an operation.
7. The new medical treatments you read about in the popular press aren't likely to be news to your doctor. If your doctor has not recommended a new treatment to you, it is probably because there are still some questions about its value, some limitations not stressed in popular reports, or some factors in your case which would make the treatment undesirable or ineffective for you.
8. Don't ask your doctor to advise you about members of your family whom he himself has not seen. He cannot risk giving an opinion about a patient of whose condition he has no firsthand knowledge.

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PROPOSED DRAFT OF PHYSICIANS

—As Reported by the Bureau of Legal Medicine of the American Medical Association—

THE SENATE and House bills (S. 2655, H.R. 6401) to reactivate selective service have now been favorably reported respectively by the Senate and House Committees on Armed Services. Each contains a special provision for the induction of physicians under forty-five years of age.

There follows the exact phraseology of each such provision and statements contained in the Senate and House Committee reports in justification of the provision.

S. 2655, introduced by Senator Gurney, a bill to provide for the common defense by increasing the strength of the armed forces of the United States, including the reserve components thereof, and for other purposes

"Sec. 4 (c) (1). Notwithstanding any other provision of this Act, the President is authorized, pursuant to requisitions submitted by the armed forces, to require special registration of and to make special calls for members of the medical and dental professions and allied specialist categories who have not attained the age of forty-five at the time of such call in such classifications as he shall determine. Persons in medical and dental categories shall be inducted in accordance with the following priorities:

First. Participants in the Army specialized training program or similar programs conducted by the Navy and persons who were deferred from training and service during World War II for the purpose of pursuing a course of instruction leading to education in one of the above professions, and who have had no active service as commissioned officers exclusive of time spent as intern.

Second. Those who did not have active service during World War II.

Third. Those who served the least numbers of full months during World War II. Persons called hereunder shall be liable for induction into the armed forces for training and service for twenty-four consecutive months, in accordance with such procedures as the President shall prescribe.

(2) No doctor of medicine or dental surgery who, on the effective date of this Act, was established in his profession in the community in which he resides shall be called for induction under the provisions of this subsection, and no such doctor of medicine or dental surgery who is a member of a reserve component of the armed forces shall hereafter be ordered to active duty for more than one month in any calendar year (except for purposes of training), if the local board within the jurisdiction of which he resides has determined that the health of the community in which he resides will be unduly jeopardized as a result of his induction or service on active duty. The foregoing provisions of this paragraph shall not apply to any doctor of medicine or dental surgery who participated in the Army specialized training program or any similar program conducted by the Navy, or who was deferred from service in the armed forces during World War II for the purpose of pursuing his medical or dental education, if he has not served on active duty as a commissioned officer for a period of more than ninety days exclusive of training duty or internship."

Excerpt from Senate Report No. 1268 on S. 2655

"Sec. 4 (c) *Special calls for certain specialist categories.* (1) To meet the health needs of the armed forces specific authority is given which permits a special registration of, and calls for, members of medical and dental professions who have not reached age 45 at the date of their induction. In view of the complex structure of the sciences allied to the broad fields of medicine, surgery, and dentistry, similar authority is intended with respect to allied specialist categories. Although full cognizance has been taken of the very serious effects which would eventuate if excessive numbers of personnel mentioned in this subsection were to be withdrawn from civilian communities for service in the armed forces, no restrictive numerical limitations have been placed upon the executive department in this particular connection. The responsibility for safeguarding the health of the armed forces is primarily an executive matter, as is the proper utilization of manpower and material resources in meeting civilian needs. The committee feels that the details of allocating, between the

continued on page 384

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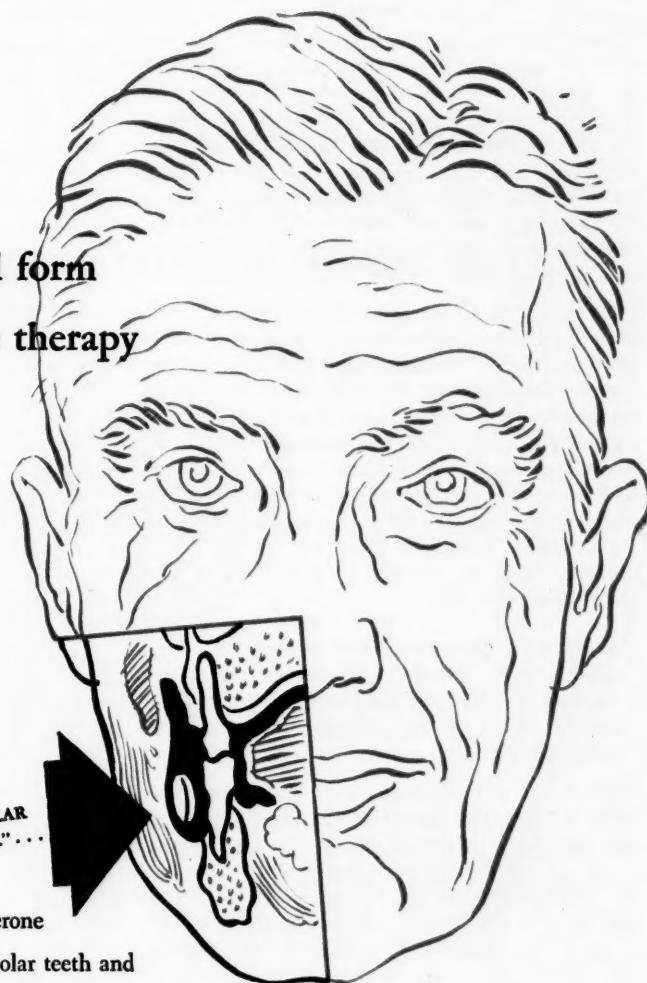
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¹. Lisser, H.: Calif. & West. Med., 64: 177, 1946.

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PROPOSED DRAFT OF PHYSICIANS

continued from page 382

armed forces and the civilian population, the personnel referred to in this subsection, comes within the recommendations expected of the National Security Resources Board and its Medical Advisory Committee, and that the fixing by statute of definite numbers of practitioners to be taken into the armed forces could conceivably result in a serious imbalance within either the armed forces or the civilian population in the event of emergencies not foreseeable at the present moment.

(2) However, as an extra safeguard for communities having few doctors in relation to their medical needs, this paragraph further provides that no doctor or dentist shall be called from a community in which the local board shall determine that his induction or call to active duty will unduly jeopardize the health of such community. This limitation would not apply to doctors who received their education under the Army specialized training program or similar programs, or who were deferred from service in World War II to complete their education."

H. R. 6401, introduced by Congressman Andrews, N. Y., a bill to provide for the common defense by increasing the strength of the armed forces of the United States and for other purposes

"Sec. 4 (c) (1). Notwithstanding any other provision of this Act, except sections 20 (b) and 23, the President is authorized, pursuant to requisitions submitted by the armed forces, to require special registration of and to make special calls for members of the medical, dental, osteopathic, veterinary, pharmacy, and optometric professions, who have not yet reached the age of forty-five at the time of such call, in such professional categories as he shall determine, and persons called hereunder shall be liable for induction for not to

RHODE ISLAND MEDICAL JOURNAL

exceed twenty-four months of service in the armed forces: *Provided*, That during the life of this Act there shall be, in the Army, including the Air Force, and in the Navy, including the Marine Corps, a ratio to total active strength of not to exceed five doctors of medicine and two dentists per one thousand men, one osteopath per five thousand men, one veterinarian per two thousand men, and one pharmacist and one optometrist per three thousand men.

(2) In inducting persons pursuant to paragraph (1) of this subsection, the President shall induct, in the following order of priority:

First. Those who participated as medical or dental students in the Army specialized training program or similar programs administered by the Navy, and persons who were deferred from service during World War II for the purpose of pursuing a course of instruction leading to education in one of the above professions, and have had no active duty as commissioned officers.

Second. Those who participated in the Army specialized training program or similar programs administered by the Navy and who have served on active duty as commissioned officers for less than twenty-four months (exclusive of time spent as intern).

Third. Those who are less than thirty-five years of age and have had less than ninety days' prior active honorable military or naval duty.

Fourth. Those who are over thirty-five years of age and have had less than ninety days' prior active honorable military or naval duty.

Fifth. Those whose total active honorable military or naval duty is less than twenty-four months.

Sixth. Others as prescribed by the President."

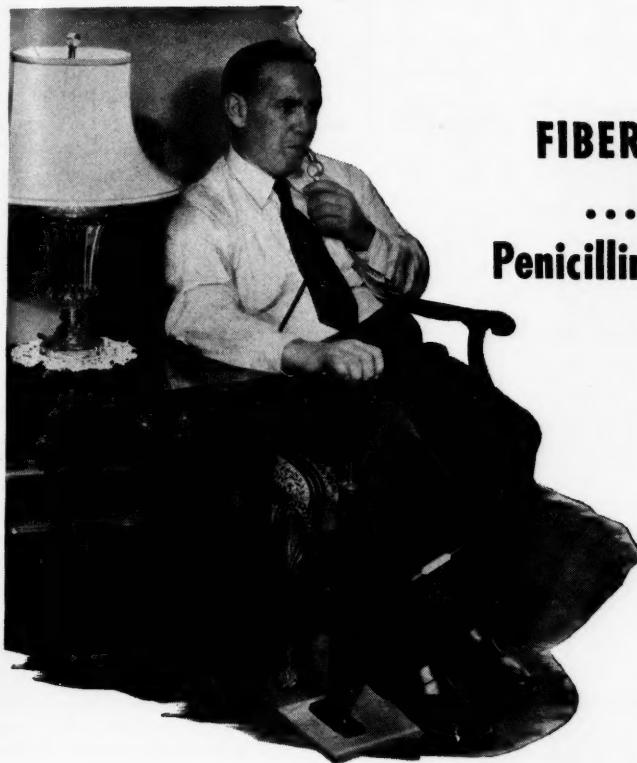
Excerpt from House Report No. 1881 on H. R. 6401

"Subsection (c) of this section (Section 4) renders doctors, dentists, osteopaths, veterinarians, pharmacists, and optometrists especially liable to service up to the age of 45 for a 2-year period of service. The committee imposed numerical limits on the numbers of such professional persons who could be inducted. The subsection requires that these persons can be inducted in only such numbers as necessary to maintain the following ratios to active-duty strength: Doctors, 5 per 1,000; dentists, 2 per 1,000; osteopaths, 1 per 5,000; veterinarians, 1 per 2,000; pharmacists and optometrists, 1 per 3,000. The committee also specified that these persons could be inducted only pursuant to specified priorities which are determined to be as follows: The first group are those without any active commissioned service who were educated at Govern-

continued on page 386

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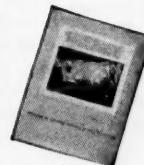
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†Finke, Walter, M.D., Simplification of penicillin aerosol therapy for home treatment, American Practitioner 1: 643-644, Aug. 1947.



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RHODE ISLAND MEDICAL JOURNAL

PROPOSED DRAFT OF PHYSICIANS

concluded from page 384

ment expense during the war and those without any active commissioned service who were deferred from military or naval service during the war to complete their education. The second group is those who were educated at Government expense and have had less than 2 years of active commissioned service in the armed forces. The third group is those under 35 who have had less than 90 days' service. Next are those over 35 with less than 90 days' service. Next, those with less than 2 years' service; and lastly, others as specified by the President."

REPORT OF HEALTH INSURANCE COMMITTEE

concluded from page 380

mium charge. They also indicate the more liberal provision of insurance contracts written for sale under the program of the Rhode Island Medical Society.

Our program is open to the non-profit Blue Cross organization of Rhode Island. The Society has accorded it the same opportunity to join with other insurance companies, profit and non-profit, in providing a contract including at least the basic provisions set forth by the Society. We sincerely hope that the Blue Cross of Rhode Island may eventually see its way clear to participate without being accorded any special underwriting privileges not common to all companies operating under the plan.

The plan we have evolved within our Society will have to be evaluated over a period of years to determine its true success. Our program is under the supervision of the public directly through the state insurance commissioner. It has the backing of the major insurance companies of America, including the great Metropolitan Life Insurance Company, long a leader in the promotion of outstanding health programs. Its service feature is guaranteed by the medical profession of Rhode Island, and its indemnity benefits are most liberal.

We have confidence in the insurance industry of this country to make this plan a successful contribution to the social security of the people of Rhode Island.

*Committee on Health Insurance*ROCCO ABBATE, M.D., *Chairman*

CHARLES J. ASHWORTH, M.D.

J. MURRAY BEARDSLEY, M.D.

ARCADIE GIURA, M.D.

CHARLES L. FARRELL, M.D.

LOUIS CERRITO, M.D.

SAMUEL ADELSON, M.D.

HENRI GAUTHIER, M.D.



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10 cc of Aqueous Diluent accompanies each vial. The concentration desired per cc may be obtained by varying the amount of diluent used.

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**HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY**

Report of Meeting Held on May 5, 1948

AREGULAR MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, May 5, 1948. The meeting was called to order at 8:30 p.m. by the President, Arthur H. Ruggles. The following were in attendance:

Rocco Abbate, M.D.
 Robert Baldridge, M.D.
 J. Murray Beardsley, M.D.
 Alex M. Burgess, M.D.
 James Callahan, M.D.
 Peter Pineo Chase, M.D.
 Paul C. Cook, M.D.
 G. Edward Crane, M.D.
 Morgan Cutts, M.D.
 William P. Davis, M.D.
 Donald DeNyse, M.D.
 Augustine W. Eddy, M.D.
 Charles L. Farrell, M.D.
 David Freedman, M.D.
 Isaac Gerber, M.D.
 Henry Hanley, M.D.
 Peter F. Harrington, M.D.
 Robert Henry, M.D.
 William A. Horan, M.D.
 Russell R. Hunt, M.D.
 Albert H. Jackvony, M.D.
 Louis I. Kramer, M.D.
 Herman A. Lawson, M.D.
 Earl J. Mara, M.D.
 Edward A. McLaughlin, M.D.
 John C. Myrick, M.D.
 Joseph C. O'Connell, M.D.
 Edwin B. O'Reilly, M.D.
 Arthur H. Ruggles, M.D.
 Daniel V. Troppoli, M.D.
 George W. Waterman, M.D.
 Guy W. Wells, M.D.

Also in attendance were Drs. Earl F. Kelly and James P. Healy of Pawtucket, Dr. Francis B. Carroll, New England Regional Director of the Veterans Administration, Mr. Charles W. Williamson, Legal Counsel and Mr. John E. Farrell, Executive Secretary.

SECRETARY'S REPORT

The Secretary submitted his report, a copy of which had been furnished to each delegate, in

which actions of the Council relating to National Emergency Medical Service, membership of the Society in the Council of the New England State Medical Societies and the Conference of Presidents and other officers of State Medical Associations, the purchase and distribution of copies of the American Medical Association's principles of medical ethics for the membership of the Society, the memorial tablet to fellows who died while in military service during World War II, and the developments relative to the Fiske Fund, were listed.

It was moved that the report be accepted and placed on file.

**RECOMMENDATIONS FROM
THE COUNCIL**

The Secretary submitted recommendations from the Council.

*Nominations for officers and Standing Committees
for 1948-49*

A motion was made and seconded that the list of nominations for officers and standing committees of the Society to serve for a twelve month period from May, 1948, to May, 1949, be accepted. There were no counter nominations from the floor and therefore the motion was unanimously adopted. (The complete list of the elected committees will be published in the May issue of the RHODE ISLAND MEDICAL JOURNAL.)

The Annual Meeting in 1949

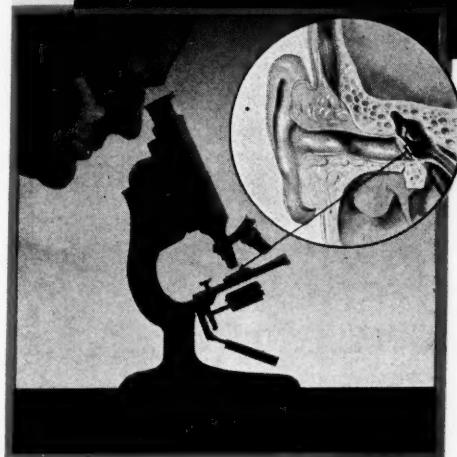
The Council recommends to the House of Delegates that the annual meeting of the Society in 1949 be held on Wednesday, May 11, and Thursday, May 12, and that the Committee on Scientific Work and the Annual Meeting give consideration to the invitation of the Councillor from Newport that the meeting be held in that city. It was moved and seconded that the recommendation be adopted. The motion was carried.

Appointments to the Curative Center

The Council recommends that the advice and consent of the House of Delegates be given to the proposal of the Acting Director of the State Department of Labor that he re-appoint Dr. Edward A. McLaughlin and Dr. Albert H. Jackvony as members of the Advisory Board to the Curative Centre. The motion was made and seconded that

continued on page 390

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HOUSE OF DELEGATES
continued from page 388

the recommendation be adopted. The motion was adopted.

VETERANS HOSPITAL IN PROVIDENCE

The Secretary reported communications from the Veterans Administration in Washington and from the regional office in Boston in answer to the proposal of the House of Delegates of the Rhode Island Medical Society to have a committee to assist in the problems of staff organization of the Veterans Hospital in Providence.

Dr. Arthur H. Ruggles stated that he had invited Dr. Francis B. Carroll, New England Regional Director of the Veterans Administration, to address the House and to explain the position of the Veterans Administration in the matter at hand.

At the request of the Pawtucket delegation, the Secretary read a resolution adopted at a meeting of the Pawtucket Medical Association on April 29, 1948, which read as follows:

"WHEREAS, we have learned through the press and radio that Dr. Francis B. Carroll, Veterans' Administration Director for New England, has named a Dean's Committee to correlate the medical services of the Veterans' Hospital and teaching program of Brown University,

WHEREAS, such committee has been appointed by Dr. Henry M. Wriston of Brown University,

WHEREAS, said appointed committee is contrary to and in disagreement with a prior committee duly elected by the House of Delegates of the Rhode Island Medical Society, after the various hospitals in the state had submitted nomination,

BE IT RESOLVED, that the members of the Pawtucket Medical Association, duly assembled,

RHODE ISLAND MEDICAL JOURNAL

- (1) Re-affirm our faith in the democratic process of government both within and without our organization.
- (2) Re-affirm our faith in the ability of the Committee duly elected by our policy making body, the House of Delegates, of the Rhode Island Medical Society,
- (3) Feel strongly that members who have accepted positions on Dr. Wriston's committee, having prior knowledge of the wishes of the Rhode Island Medical Society, have acted most unwisely,
- (4) Urge the House of Delegates to re-affirm its stand and support the duly elected committee of the Rhode Island Medical Society,
- (5) Instruct delegates of the Pawtucket Medical Association to vigorously oppose any change in the Rhode Island Medical Society Committee as now constituted,

BE IT FURTHER RESOLVED, that copies of this resolution be sent to the Secretaries of the Rhode Island Medical Society, and all district medical societies, all hospital staffs of the state and Dr. Carroll."

There was lengthy discussion with many members of the House of Delegates participating.

A very brief summary (complete notes are on file at the Society's executive office) of the highlights of the discussion is as follows:

Dr. Carroll reviewed the Veterans Administration program for hospitalization of veterans, and outlined the purpose of a Dean's Committee, citing as one of its major roles that of assisting in a teaching program, and naming consulting and attending physicians to the hospital. To date no consultants or attending physicians have been named for the Providence Veterans Administration Hospital, but the local Dean's Committee will make recommendation to him for appointments. The Dean's Committee serves without compensation.

In March, 1946, Dr. Winthrop Adams, then regional Veterans Administration medical director, expressed the hope that Brown University might be of help in forming the Dean's Committee for Rhode Island. Subsequently, Dr. Wriston, president of Brown, was approached on the matter and he designated the department of medical sciences of the University to assist in the task.

Dr. Carroll reported that he did not know of the plans of the Rhode Island Medical Society as made known to Dr. Paul R. Hawley, and as enacted by the House of Delegates. He also stated that it has not been the policy of the Veterans Administration to consult any state medical societies in the matter of Dean's Committee, but he will now

continued on page 392

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HOUSE OF DELEGATES

continued from page 390

call to the attention of the Central Office the importance of such a step.

In explanation of his acceptance of service with the Dean's Committee, Dr. Alex M. Burgess stated that he first heard of the contemplated plan for such a committee in Rhode Island on October 17, 1947. He had a letter from Dr. Carroll stating that a Dean's Committee probably would be formed in connection with Brown University. At the time of the House of Delegates meeting in November he suggested in the report of the Committee on Post-graduate Education that the committee cooperate with the Veterans Administration if they sought assistance. It was his understanding that a Dean's Committee could not be established through a medical society but would have to be established through a university. He was later asked by Dr. Carroll to come to Boston and to serve as a consultant to the Veterans Administration regional office, but this work has nothing to do with the Dean's Committee. On February 24, 1948, Dr. Cushing wrote to Dr. Wriston and he recommended the department of medical sciences as the personnel for the committee. On March 5, 1948, the committee was appointed.

In answer as to how the committee could now be changed, Dr. Carroll reported that the Dean's Committee itself could change its membership. The question of a resolution to Dr. Magnuson and Dr. Carroll to express the wishes of the Society was discussed, and the discussion was concluded with the following motions, both of which were adopted:

1. Dr. Joseph C. O'Connell moved that the House of Delegates request the Veterans Administration, through Dr. Francis B. Carroll, regional medical director for New England, that he increase the membership of the Dean's Committee in Rhode Island by the addition of at least three members who will represent the other academic colleges in Rhode Island other than Brown University.

2. Dr. Earl Mara moved that the House of Delegates re-affirm its appointment of its statewide committee elected by the House of Delegates in January, 1948, and that it instruct that Committee to serve as advisors to the Dean's Committee of the Veterans Administration in Rhode Island, that it also keep the House of Delegates informed from time to time of the progress and development of the Veterans Administration hospital program in Rhode Island.

Annual Report (1947) of the Treasurer

In the absence of Dr. Charles J. Ashworth, Treasurer, his annual report for 1947 was presented by Dr. Morgan Cutts, Secretary. A mimeographed summary of the introduction to the report

continued on page 394

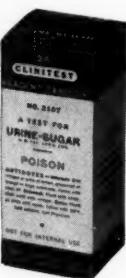
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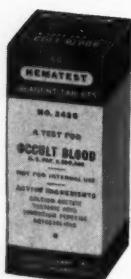
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HOUSE OF DELEGATES

continued from page 392

had previously been submitted to each delegate. By consent of the House the reading of the financial statement was omitted when Dr. Ruggles reported that it had been previously read to the Council and approved by that body.

Dr. Charles L. Farrell moved that the report of the treasurer be adopted. The motion was seconded and unanimously carried.

REPORTS OF COMMITTEES

Report of the Health Insurance Committee:

Dr. Rocco Abbate, chairman of the Health Insurance Committee, presented a progressive report listing the 13 major insurance companies as participants under the plan and explaining the work of the committee during the past several months. A complete copy of the report was submitted to each member of the House of Delegates. (The report will be published in the June issue of the R. I. MEDICAL JOURNAL.)

Child Health Service Study:

Dr. Ruggles called to the attention of the House that a progress report from the local committee of the American Academy of Pediatrics participating in the Child Health Services Study had been submitted by Dr. Buffum and a copy had been sent to each member of the House of Delegates. There was no action taken on this report.

Committee on Postgraduate Education:

Dr. Alex M. Burgess, chairman of the Committee on Postgraduate Education, reported that a list of meetings, clinics and similar educational exercises held at the various hospitals which members of the Rhode Island Medical Society are privileged to attend will be published in the May issue of the RHODE ISLAND MEDICAL JOURNAL. The medical profession of the state is thus offered an excellent opportunity to keep in touch with modern medicine in its various branches.

He called attention to the list of specialists submitted to the House of Delegates as a result of the tabulation of a card survey to the members conducted by the Committee. He stated that this list will not be published and that it is by no means complete, and that any member noting any errors or omissions is requested to communicate with the Executive Office of the Society in order that the list may be corrected.

MISCELLANEOUS BUSINESS

The Secretary reported the receipt of a resolution from the Woonsocket District Medical Society relative to the eligibility of certain physicians in that area for licensure. It was moved that the resolution be referred to the Committee on Public Policy. The motion was seconded and adopted.

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Resolution upholding action of the American Medical Association's Board of Trustees

Dr. Rocco Abbate presented the following resolution:

WHEREAS the General Manager and the Board of Trustees of the American Medical Association, acting in the best interests of the employees of the Association, have provided for them a plan of prepaid hospital and medical care insurance on a group basis, sharing with the employees the cost of such insurance, and

WHEREAS this action has been unjustly and unfairly criticized by many non-profit hospital and medical care organizations, and even by some medical societies, because the insuring company is not organized wholly for non-profit, and WHEREAS, the insurance jointly purchased by the Association and its employees provides more benefits at a lower cost than obtainable through a non-profit plan, and

WHEREAS, competition in free enterprise is one of the bulwarks of American economic freedom,

THEREFORE BE IT RESOLVED, that the Rhode Island Medical Society express its approval of the sound action taken by the General Manager and the Board of Trustees of the American Medical Association in this matter, and express its disapproval of the unwarranted resolutions and actions directed against the aforesaid officers in this instance.

It was moved and seconded that the resolution be adopted.

Resolution relative to the American Medical Association Seal of Acceptance for the Rhode Island Surgical Plan:

Dr. Charles L. Farrell presented the following resolution:

WHEREAS the Rhode Island Medical Society has sponsored a prepaid, voluntary surgical-obstetrical insurance plan under which all insurance companies licensed in Rhode Island, including the Hospital Service Corporation (Blue Cross) of Rhode Island, may equally participate, and

WHEREAS all policies under the Rhode Island Plan are subject to the approval of the Rhode Island Medical Society and can be sold only with such approval, and

WHEREAS, as of this date, May 5, 1948, thirteen major insurance companies, profit and non-profit, including the Metropolitan Life Insurance Company, have submitted policies for approval by the Rhode Island Medical Society, and

continued on next page

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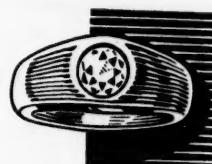
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WHEREAS some of these great insurance companies are already selling policies under the Plan, and at premium rates comparable to the so-called non-profit plans in other parts of the country, and in many instances with wider coverage, and

WHEREAS the Rhode Island Medical Society has been informed that the Council on Medical Service of the American Medical Association has established a policy to require a one year period of operation for plans underwritten by private insurance carriers before such plans are formally considered for receiving its seal of acceptance, THEREFORE, BE IT RESOLVED, that the Rhode Island Medical Society request that the House of Delegates of the American Medical Association discourage such discriminatory regulations as regards plans sponsored and approved by state or county medical societies as being contrary to the purposes for which the Council on Medical Service was established, as being unfair to the insurance industry of this country which the Council on Medical Service itself, at the Cleveland Session this year, reported has insured an estimated 44 million persons under health and accident coverage, and as being a penalty to the state or county medical society that does not

RHODE ISLAND MEDICAL JOURNAL

endorse the non-profit program exclusively.
The resolution was adopted.

Blue Cross-Blue Shield Merger:

Dr. Arthur H. Ruggles read communications from the Council on Medical Service of the American Medical Association urging each state to have representatives at a meeting at the American Medical Association headquarters on June 19, to discuss a proposed Blue Cross, Blue Shield merger on the national level. He also read communications from a physician in Oregon and from the New Mexico Physicians Service opposing such a merger. He stated that an effort would be made to have a member of the Society's Health Insurance Committee attend this meeting.

Resolution Regarding Cash Sickness Study:

Dr. Charles L. Farrell presented the following resolution:

WHEREAS the House of Delegates of the American Medical Association in meeting at San Francisco in July, 1946, adopted a resolution presented by the Rhode Island Medical Society which requested that the American Medical Association, through the proper Council or Bureau, make a complete study of the existing and proposed compulsory temporary disability compensation programs, such as the compulsory Rhode Island Cash Sickness Compensation plan, and that a report of the findings of such a study, particularly as regards the medical phases of the programs, be submitted to each of the constituent state medical societies before January, 1947, and

WHEREAS such a complete study report has never been made to the state medical societies in accordance with this action of the House of Delegates, and

WHEREAS such a study is now being made under the sponsorship of the National Physicians Committee,

THEREFORE, BE IT RESOLVED that the Rhode Island Medical Society, being well aware of the far-reaching effects of a program of compulsory cash sickness compensation, express its dissatisfaction that the study it requested of the American Medical Association has not been made, and is now being undertaken by an organization neither authorized nor qualified to speak for the American Medical profession. The resolution was adopted.

The House of Delegates meeting was adjourned at 11:20 p.m.

Respectfully submitted,

MORGAN CUTTS, M.D., Secretary

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DISTRICT MEDICAL SOCIETY MEETINGS

KENT COUNTY MEDICAL SOCIETY

The April meeting of the Kent County Medical Society was held on the sixth at 8:30 p.m. at the headquarters of the Kent County Memorial Hospital Drive, 10 St. John Street, West Warwick, Rhode Island.

Minutes of the previous meeting were read and accepted.

Two candidates, Doctors Peter Koch and Carl E. Anderson, both of West Warwick, were admitted to Society membership.

Dr. Jeannette Vidal, President, proposed a joint fall meeting with members of the Kent County Dental Group for discussion of mutual problems. With the Kent County Memorial Hospital now a physical probability in the near future, this suggestion was favorably considered and so voted.

Dr. Vidal further suggested a medical society sponsored dinner-dance be held in conjunction with the medical auxiliary. This idea was popular but was tabled for later discussion relative to time and place.

The meeting was brought to early adjournment at 9 p.m. as members present were to meet the Memorial Hospital Drive directors the same evening.

Respectfully submitted,
FRANCIS D. LAMB, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was called to order by the President, Dr. Earl J. Mara, at 7 p.m., April 29, 1948, in the Nurses Dining Room of the Memorial Hospital.

The minutes of the previous meeting were read by the Secretary and accepted as read.

The following resolution was introduced and unanimously passed:

WHEREAS, we have learned through the press and radio that Dr. Francis B. Carroll, Veterans' Administration Director for New England, has named a dean's committee to correlate the medical services of the Veterans' Hospital and Teaching Program of Brown University,

WHEREAS, said appointed committee is contrary to and in disagreement with a prior committee duly

elected by the House of Delegates of the Rhode Island Medical Society, after the various hospitals in the state had submitted nomination,
BE IT RESOLVED, that the members of the Pawtucket Medical Association, duly assembled,

(1) Reaffirm our faith in the democratic process of government, both within and without our organization,

(2) Reaffirm our faith in the ability of the Committee duly elected by our policy making body, the House of Delegates, of the Rhode Island Medical Society,

(3) Feel strongly that members who have accepted positions on Dr. Wriston's committee, having prior knowledge of the wishes of the Rhode Island Medical Society, have acted most unwisely,

(4) Urge the House of Delegates to reaffirm its stand and support the duly elected committee of the Rhode Island Medical Society,

(5) Instruct delegates of the Pawtucket Medical Association to vigorously oppose any change in the Rhode Island Medical Society committee as now constituted,

BE IT FURTHER RESOLVED, that copies of this resolution be sent to the Secretary of the Rhode Island Medical Society, all district medical societies, all hospital staffs of the state, and Dr. Carroll.

EARL J. MARA, M.D., *President*

Pawtucket Medical Association

Following a motion by Dr. G. Raymond Fox, the Chair appointed the following members to work with the director of the Rhode Island Cancer Committee: Doctors G. Raymond Fox, Chairman; Dr. Frank Hanley; Dr. Hrad Zolman.

The members then adjourned to the Nurses' Auditorium where Dr. Frederick Webster, Chairman of the evening introduced Dr. Frank C. Hamm, Chief of Urology, Brooklyn Hospital, Brooklyn, New York.

Dr. Hamm's topic was "Results in the Treatment of Prostatic Hypertrophy." He included a report of the management of 207 cases and a comparison of

continued on next page

1. Suprapubic Prostatectomy
2. Retropubic Prostatectomy
3. Transurethral Resection.

Dr. Chapian, Dr. Sprague, Dr. Chaset discussed Dr. Hamm's paper and the meeting adjourned at 9 p.m.

Thirty-two members attended.

Respectfully submitted,

KIERAN W. HENNESSEY, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Library on Monday, May 3, 1948. The meeting was called to order by President Philip Batchelder at 8:30 p.m.

With the consent of the membership the reading of the minutes of the previous meeting was omitted.

The Secretary presented a communication from the St. Joseph's Hospital inviting the members of the Providence Medical Association to attend a staff meeting there on Tuesday, May 25, at which Dr. Edward J. Waters of Jersey City was scheduled to address the group.

The Secretary reported for the Executive Committee as follows:

1. It was recommended that the annual dinner and golf tournament for the members of the Association be held, if possible, the first or second Wednesday after Labor Day.
2. Approved of the recommendation of the Committee on Pre-School Examinations that "Parents of children of pre-school age be provided with examination-forms and be encouraged to have the examinations made by the family physician." But withheld approval of these commendations that:

"Arrangements be made for the examinations of those who do not have private service at

RHODE ISLAND MEDICAL JOURNAL

some schools, in which case they would be done by the school physicians with the school nurse present" and that the executive secretary of the Association "provide a list of names of local younger physicians who would be willing for reasonable compensation to serve in the event the school physicians are not available."

The Executive Committee authorized the President to confer further with members of the Association and the Committee on this matter.

3. Authorized the President to name a committee to re-open the study of health and accident insurance for the members of the Association.

It was moved, seconded and adopted that the report of the Executive Committee be approved.

Dr. Philip Batchelder made the following announcements:

The Committee of Dr. John Ferguson and Dr. Joseph C. O'Connell has submitted the Association's tribute to the late Dr. Charles E. Hawkes and the committee of Dr. Albert H. Jackvony and Dr. Edwin B. O'Reilly presented the tribute to the late Dr. Patrick T. O'Rourke.

As a committee to prepare the Association's tribute to the late Dr. Fred Coughlin the following are named: Drs. James J. Hamilton and James F. Boyd.

Dr. Batchelder introduced as the first speaker of the evening Dr. Jesse P. Eddy, III, Senior Assistant Surgeon, the Memorial Hospital, Pawtucket, who spoke on the subject "Bilateral Non-Simultaneous Femoral Arterial Occlusion".

Dr. Eddy presented a case report with a brief review of some local experiences and deductions in embolic disease of arteries. His patient, a cardiac with fibrillation, experienced a sudden cold leg. The patient had cyanosis to the thigh and a feeble femoral pulse. The clot was removed by operation. Anticoagulants were also used. The pulse returned to the leg.

Four days later, the patient experienced a similar episode in the left leg. This was similarly treated and the patient recovered.

Dr. Ralph DiLeone, Assistant Surgeon, Department of Gynecology, Rhode Island Hospital, and Dr. Ralph E. Brown, Resident in Surgery, Rhode Island Hospital, were the second speakers of the evening discussing "Carcinoma of Cervical Stump Following Supravaginal Hysterectomy".

Dr. DiLeone stressed the increasing number of carcinomas of the cervical stumps following supravaginal hysterectomy. This fact has led gynecologists to do total hysterectomy instead of the incomplete operation. Totals can now be done safely with as low a mortality rate as the supercervical.

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which endeared him to his friends."
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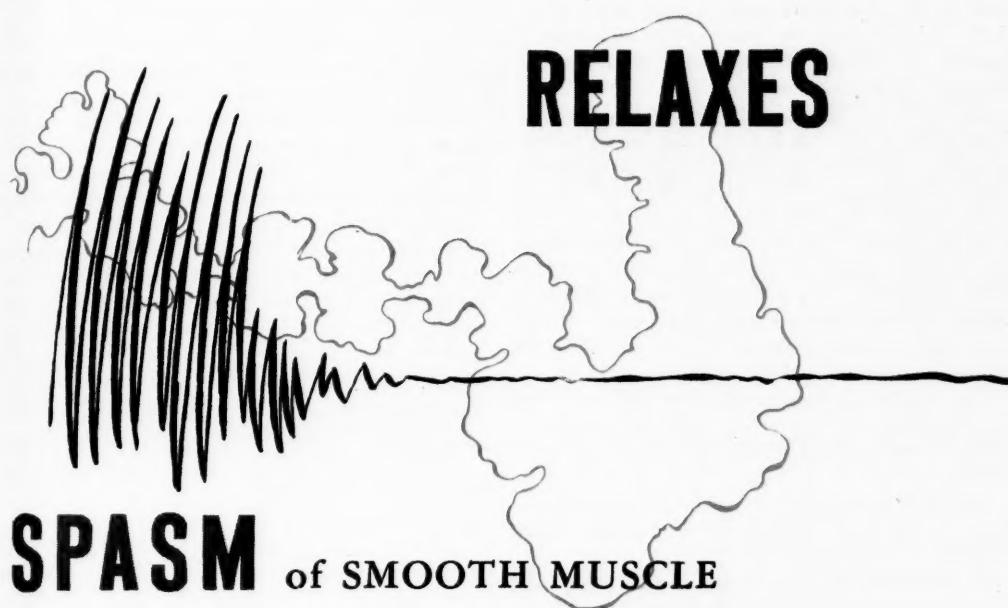
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PROVIDENCE MEDICAL ASSOCIATION
concluded from page 398

The mortality rate for total hysterectomy now is 0.2% to 0.8%.

Prior to 1934, only 18% of hysterectomies were total. Now the total operation is in the neighborhood of 65%. In 1945, at the Rhode Island Hospital total hysterectomy was performed on most patients. Of 320 totals done at the Rhode Island Hospital, no deaths resulted.

The incidence of carcinoma of the stump ranged from 2.5 to 11.3%. It is 4% at the Rhode Island Hospital. Another argument for total hysterectomy is that carcinoma of the cervix is four times more frequent in patient who have uterine fibroids. This carcinoma appeared as a rule within three years of the operation. The five year survival rate of those treated for carcinoma of the stump is comparable to those treated with intact uterus. A patient with a remaining cervical stump should report for frequent examinations.

The paper was briefly discussed by Dr. Pitts who stated that for thirty years he has not done a supracervical operation, but all total hysterectomies.

The final paper, by Dr. Howard Haggard, Director, Laboratory of Applied Physiology, New Haven, was on "Alcoholism".

Dr. Haggard feels he is now getting the public to see that alcoholism is a medical problem. About sixty million people use alcohol with no harm. About three million use it to excess. He divides these into groups.

Group 1. Symptomatic Drinkers. Fifteen to twenty per cent of the cases. They suffer from endocrine disturbances, psychoses, or epilepsy, and drink because of these ailments. In these cases, we should not attempt to treat their habits, but the underlying condition.

Group 2. Socially ill. These are not sick physically or mentally. They have no compulsion to drink. They get drunk for nothing else to do.

RHODE ISLAND MEDICAL JOURNAL

Group 3. The true alcoholic. He has an overwhelming compulsion to drink. He has a physical disturbance but we haven't discovered the cause. It is probably on a physical basis. He departs from the normal habits of drinking. Formerly the average alcoholic was forty—forty-five years of age; now we get patients in the thirty year group.

The feature that characterized him is that if he takes a drink or two, he can't stop. He has remorse afterwards as contrasted to Group 2.

True alcoholics cannot be cured. All you can get is symptomatic recovery. There is no specific therapy. A very careful physical is done first, then the remainder of the treatment falls in the realm of faith healing.

Dr. Haggard has two psychiatrists in his group but psychiatry is not used. The clinic finds out what therapy suits the particular patient and that is used. The important thing is that he be treated with the same respect you use toward a sick man.

About twenty per cent of the patients from Dr. Haggard's clinic are sent to Alcoholics Anonymous.

The meeting adjourned at 10:30 p.m.

Attendance was 105.

Collation was served.

Respectfully submitted,
 DANIEL V. TROPPOLI, M.D., *Secretary*

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IN THE EVENT OF A NATIONAL EMERGENCY

(The report below is abstracted from a special report to the House of Delegates of the Rhode Island Medical Society by Dr. Albert H. Jackvony and Mr. John E. Farrell who represented the Society at the Spring session of the Council on National Emergency Medical Service of the American Medical Association at Chicago, April 5-6, 1948)

A WHOLE NEW GROUP of special weapons—atomic bombs, biological products and chemical agents that science has made available, is projecting an unprecedented challenge to the medical profession and those associated with rendering service to the nation in the event of another war. Though war is by no means inevitable in the present world wide crisis, the very threat of it demands that the people of this country be made fully cognizant of the special weapons possible in the event of another world conflict and also that they be fully organized to cope with any disaster or national emergency that may arise.

Even the dissipation of the present threat of Communism would not warrant the acceptance of the belief that peace in our time will continue indefinitely. The atomic bomb did not merely end the war with the Japanese; it started what may be an era of great peace or of total destruction for many peoples of the world. Until people everywhere grasp the true significance of the atom bomb and allied scientific discoveries, and particularly the use of such discoveries as weapons of destruction, men in no lands may hope to resume the pattern of life that we like to call normal and peaceful.

Therefore the presentation that follows must be construed not with alarm in the sense of fear or panic, but alarm in the sense of cold reasoning of imminent danger that is intensified by the apparent lack of preparedness of this great nation which alone in the world can lead a successful defense for free men everywhere.

THE WAR THREAT

Russia is the only nation in the world today capable of waging war with the United States. The incidents that might provoke such a conflict are too well-known to require repetition or elaboration here.

But a World War III would not necessarily

mean the invasion and conquest thereby of a nation. The new special weapons referred to above, and others unknown to all nations, would be employed to paralyze and even destroy the economic power of this country. The first blow would be a special weapon aimed for mass destruction and havoc. It need not be delivered by a bombing plane travelling a long distance, but could arise from the hold of a tramp steamer at dockside in any of our great seaboard cities.

The use of such a special weapon as the atom bomb, or an offspring of it, might well seal the fate of all peoples of the world. It is fairly certain that the first atom bomb is now replaced by a more modern counterpart a thousand times more powerful. Ten bombs per city, five in the air and five in the water (except at Denver) over 25 key cities of this country would destroy completely the facilities of such cities and would let loose radioactive rays in the air to contaminate wide areas for years to come. Millions of deaths could be caused by even a single bomb over 20 populous cities.

But we have the atomic bomb! True, but it is a secret that we may well question the ability of man to retain within the confines of one group of minds, or one country. And could we, or any other nation use the atomic bomb, unless the belief that war is murder and by whatever means justified, is to prevail to the end that free society faces the threat or even the reality of annihilation?

ATOMIC WARFARE

While the possession of the atomic bomb secret is undeniably of tremendous psychological warfare value to us, it is to be regretted that the American people have so little information about the literally fantastic features of this scientific discovery which is thought more of in terms of its destructive power than for its peaceful use. The speakers at the conference divulged little that is probably new information about the scope of atomic energy for a scientist or physician. All speakers stressed the importance of public education, and the need for adequate agencies to compile, analyze and disseminate information on atomic energy outside the Atomic Energy Commission, preparing suitable literature, text books, etc.

The inherent threat in the possible misuse of atomic energy demands constant vigilance and ef-

continued on next page

fective civil defense. The role of the medical profession in such vigilance and defense will be paramount. The exercise of great care and preparation in the training of personnel resulted in no casualties at either the Manhattan project or in the post-war Pacific experiments with the atom bomb. Civil defense will require the same precautions, hence medicine must first undertake the task of educating its membership in the ramifications of atomic energy.

The devastating effect of the atomic bombings in Japan, related in press and in public meetings since the end of the war, was repeated by several of the speakers. Some of their comments bear repeating. The gamma radiation equalled several thousand tons of radium, and in the water experiment it was estimated that there was from one to a hundred tons of radium in the mist which in great part could be wind-blown to distant shores, thus constituting a continuing hazard of contamination. This latter point was forcibly brought out with the illustration that cumulus clouds loaded with radioactive substances might well circle the globe, dropping their deadly cargo in widely scattered localities, even to the extent of contaminating ground, thus affecting the food supply now and for future generations.

Likewise the contamination from a water explosion could wreak equal havoc on the world. For example, the illustration was offered that a bomb in Lake Michigan could contaminate the water down to the mouth of the St. Lawrence, thence into the fishing banks off New Newfoundland, thereby seriously affecting the fish food supply of the nation.

In an air detonation the heat and fire of the bomb are blown out by the accompanying blast which in turn adds to the devastation as was evidenced at Hiroshima. Cities are weak at their roof tops, hence the crumbling of structures was immediate, and the flying debris added to the toll of casualties. Death from the blast occurred in the

first 24-48 hours, and within the first week the serious effects of gamma radiation is evidenced with the gastro-intestinal tract most seriously damaged; later the disintegration affects the bone marrow. Thus all persons living after such an explosion must be screened to check the evidence of radiation.

The extent to which the civilian population must be educated and trained in its own defense and care is best illustrated by the fact that at Hiroshima 260 out of the 300 available physicians were killed or injured. 75% of the nurses and technicians suffered similar fates, and all the hospitals and public utilities were destroyed.

In the light of even these few salient views can there be any question of the need for an alert civil defense for a national emergency in general, and a war involving special weapons in particular?

CIVIL DEFENSE

The Civil Defense Board, advisory to the Secretary of Defense, has already been established with Russell J. Hopley as its director to draft a national program. The functions of this organization will include the preparation of a defense program calling for permanent organizations, the initiation of interim measures for civil defense while legislation is pending to set in motion definite plans, the possible establishment of training centers where monitors will be educated in a radiological defense system, and the preparation in general for a national disaster with complete inventory of emergency medical and hospital and allied facilities.

The Civil Defense Board is apart from the War Department, and it also will not interfere in any manner with the National Resources Advisory Planning Board which still has jurisdiction over the allocation of essentials including manpower.

Medicine is expected to take leadership in planning to aid on the medical implications of radioactive substances, educating both its own membership and the public. Physicians would join with other scientists in training technicians in the use of instruments to detect radio activity, and would in general set up active committees within their societies for emergency administration available to answer a call from the government in a national emergency.

Dr. Bortz, president of the American Medical Association, reported on the study of an atomic energy steering committee of the Philadelphia County Medical Society which supported a plan that communities be regionally divided with certain major groups within each responsible for definite restricted duties. These groups, as outlined by the Philadelphia committee are as follows:

Group One: Monitors. This assignment included the appointment of persons qualified to utilize the



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new instruments of precision for the identification of radioactive substances.

Group Two: For blood and blood substitutes

Group Three: Psychiatry (morale)

Group Four: Emergency Administration

Group Five: Epidemiology

Group Six: Education and Public Relations

* * *

There is no presently known method of protecting those in the immediate neighborhood of an atomic bomb when it explodes. Nevertheless, since the Los Alamos experiment opened the Atomic Age, a great deal has been learned about mitigating the secondary effects of ionizing radiation and about protecting survivors who have received less than a lethal dose.

Many lives may be saved by widespread knowledge of therapeutic measures among physicians, and many more by a general understanding of preventive measures which can be taken by the general population.

The real difference between ordinary high explosives and atom bombs in the enormous amount of radiant energy produced by the latter—energy covering the whole range of wave lengths from heat waves to million-volt gamma waves.

The radiant energy may be divided into two types: ionizing and non-ionizing. The most important type of injury noted in Hiroshima and Nagasaki was, of course, that due to the ionizing component of the radiant energy from the bomb. Four known kinds of penetrating radiation can be expected within the immediate area of the blast. They are:

First, gamma radiation, which is essentially the same as x-ray. In an atom bomb explosion, however, these are 200,000,000 volt x-rays. They are lethal to anyone within roughly a mile of the blast, do serious damage to those as close as a mile-and-a-half, but their range is limited to approximately two miles. They move with the speed of light and most of them are produced at the instant of explosion.

Second, neutron beams, streams of heavy atomic particles shot out in all directions within a millionth of a second of the explosion. They have slightly less range than gamma rays. Both gamma rays and neutron beams passing through matter such as blood, bone or flesh, produce extensive ionization of the atoms which made up body cells, which results in the breakdown of chemical bonds, causing profound alterations in cellular function. The fact that some kinds of cells, such as certain types of cancer cells, are affected more easily than others is the basis of radiation therapy. Whatever damage is done in this way is instantaneous, although observable symptoms may not appear for some time.

continued on next page

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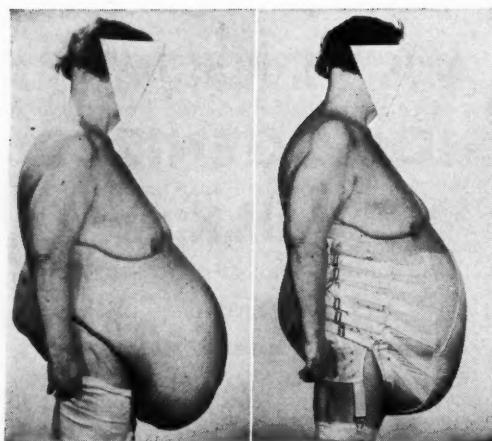
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IN THE EVENT OF A NATIONAL EMERGENCY *continued from preceding page*

Neutron beams, however, have another effect, new in medical science. Neutrons are captured in elements contained in human cells, producing new elements which are themselves radioactive, and may remain so for a long time.

Third, are beta rays, streams of electrons which rarely penetrate the skin and whose effects will be found chiefly on the surface; and,

Fourth, are alpha particles, the nuclei of helium atoms, which do not get through the cornified, or horny tissue, layer of the skin. Because of their low penetrating power, it is not likely that either the beta rays or the alpha particles resulting directly from the explosion will cause fatal injury.

There is not much even a medical man can do about the immediate radiation from an atom bomb explosion. But in such an eventuality the immediate requirement will be for rescue work on a large scale and treatment for fractures, contusions, lacerations and burns. Here physicians and laymen will be on familiar ground.

Also, some aid may be given to victims of many sorts of secondary radiation dust spread by the explosion, radioactivity caused by neutron captured by atoms, or radioactive spray if the bomb is dropped in water. Against this secondary radiation, various safeguards can be provided, and it is essential that physicians be trained in safety measures. Army, Navy and Atomic Energy Commission scientists, as well as civilians interested in radiation therapy, are hard at work on the problem and substantial progress is being made. One important line of research is in the efficacy of blood transfusions, since it has been established that one of the most serious effects of radiation is damage to the blood-forming elements such as the bone marrow. A person tided over until normal function is resumed may be saved.

A major function of the physician after such a disaster would be to act as public health officer. Most food in the affected area would not be unfit for consumption, but it would all have to be surveyed before it could safely be eaten. All the water in the region would probably contain radio-active isotopes, slow poison to anyone drinking it, but research is in progress on methods of removing radioactive substances. Obviously the usual boiling or chlorination would be useless. There is some indication that filtration and other methods can be developed.

Physicians would have a heavy responsibility in supervising the decontamination of not only food and water but of refugees, by means of complete change of clothing, bathing, etc. This requires familiarity with the use of detecting instruments

continued on page 406

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RHODE ISLAND MEDICAL JOURNAL

IN THE EVENT OF A NATIONAL EMERGENCY

concluded from page 404

such as the Geiger counter, and a knowledge of the kinds of persistent radiation to be expected. (People escaping from the area where a bomb has exploded may find their wearing apparel sufficiently radio-active to constitute a menace to others.) This problem has already come up in hospitals where patients are being treated with large amounts of radio-active material.

Besides flash burns from enveloping hot gases, such as result from any powerful explosion, blisters similar to skin burns and sunburn are likely to appear on the skin of atom bomb victims. In Japan, burns and blisters appear to follow a definite pattern, showing up within five minutes on those close to the explosion. At nearly a mile away, they did not show for several hours, and at greater distances, up to about two miles, the appearance of burns and blisters was even longer delayed.

Of the superficial effects perhaps the most alarming is the falling out of the hair. While bound to cause a bad psychological effect, it is due to superficial radiation and is not serious in itself. The hair will return if the patient has not received a lethal dose of radiation.

Immediately after a bomb blast those in the vicinity who escape immediate death from shock, burns or falling debris may appear to have suffered no ill effects at first. But within a few hours, victims seriously affected will feel nauseated and start to vomit. This may pass in a day or so. But at the beginning of about the second week when the hair starts to fall out, the feeling of general malaise, experienced in the first few hours, may return accompanied by fever. There is likely to be bloody diarrhea. Examination will show that the white blood count has fallen to a very low level. Death may come very quickly, or there may be anemia and general debility over a long period with eventual recovery.

Physicians must be prepared to expect such a syndrome and to take nothing for granted about the condition of the patient during the first few days.

There is a parallel in our experience with heavy bombing of cities from the air in World War II. This type of warfare was an innovation, and at first physicians had virtually no information concerning the effect of shock waves of that magnitude on the human body. Scores of people in the neighborhood of bursting bombs died, although they had apparently suffered no injuries. The knowledge of what could be done to save those people was acquired the hard way because medical science had not foreseen such a problem.

The threat of the atom bomb is at least now recognized and we have already a growing body of knowledge which can be mastered while an emergency is still remote.

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**WOMAN'S AUXILIARY
to the
RHODE ISLAND MEDICAL SOCIETY**

REPORT OF MARCH MEETING

A meeting of the Woman's Auxiliary to the Rhode Island Medical Society was held on March 4, 1948, at the Rhode Island Medical Library. Mrs. Herbert E. Harris, President of the Auxiliary, called the meeting to order at 2:00 p.m. In a few opening remarks Mrs. Harris told the group of the purpose of the Auxiliary.

The Secretary, Mrs. Charles L. Farrell, read her report. It was approved.

The Treasurer, Mrs. Jesse P. Eddy 3rd., reported a balance on hand of \$571.31 with a membership of over two hundred.

The Secretary read a news letter from Mrs. Eustace A. Allen, President of the National Woman's Auxiliary.

Mrs. Herman A. Lawson reported for the Legislative Committee. They recommended that their Committee be enlarged.

Plans for extension of our membership campaign were outlined by Mrs. Bertram H. Buxton and Mrs. Joseph C. Kent of the Organization Committee.

In the absence of Mrs. Henry S. Joyce, Chairman of the Revisions Committee, Mrs. Arcadie Giura reported for that Committee. She stated that they were continuing their work on the Revisions of the By-Laws and were making progress.

The Program Chairman, Mrs. Charles F. Gormly, detailed her Committee plans for the Annual Meeting to be held on May 12, 1948, at the Plantations Club. Luncheon will be served at 12:30 p.m.

The business meeting adjourned at 2:45 p.m.

Our President, Mrs. Harris, introduced Dr. Arthur H. Ruggles, President of the Rhode Island Medical Society. Dr. Ruggles stated that the Woman's Auxiliary plays a great part in promoting public relations.

He then introduced the speaker of the afternoon, Dr. Edward A. McLaughlin, Director of

Health for the State of Rhode Island. Dr. Ruggles paid tribute to Dr. McLaughlin's ability as a Public Health Administrator.

Dr. McLaughlin congratulated the Woman's Auxiliary on their formation and work and stated that they would stimulate interest in medical practice and medical care. He also feels that public health, medical care and the practice of medicine, are closely allied.

He then outlined the growth of the State Health Department.

Thirteen years ago the budget of the State Health Department was \$130,000 with 8 nurses and 52 employees. Today the budget is \$775,000 with 35 nurses, 172 full-time, and 85 part-time workers. The department is divided into fifteen organization units or bureaus.

The present functions of the Rhode Island State Health Department are:

- 1) To provide a complete public health program at State Level.
- 2) To take all action necessary for the protection of the lives and health of the citizens of the State.
- 3) To correlate the public health activities of all federal, state, municipal and private agencies in so far as they deal with matters of public health in Rhode Island.

As national programs have been developed it is apparent, Dr. McLaughlin stated, that "Public Health Services are entering into the realm of private health".

Commenting on the situation regarding hospitals, Dr. McLaughlin stated that at the present time those institutions faced with greatly diminished income and smaller endowments seem to have no alternative other than federal aid. Following the address the speaker answered questions from the audience.

The meeting adjourned at 4:00 p.m.

Respectfully submitted,
MARY A. FARRELL, Secretary



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SECOND ANNUAL CONVENTION

Woman's Auxiliary to the Rhode Island Medical Society

THE SECOND Annual Luncheon Meeting of the Woman's Auxiliary to the Rhode Island Medical Society was held in the Auditorium of the Plantations Club on May 12, 1948, at 12:30 p.m.

Dr. Arthur H. Ruggles, President of the Rhode Island Medical Society, extended greetings to the Auxiliary from the Rhode Island Medical Society. He congratulated the Auxiliary on the progress in its first year, and urged the women to cooperate with the local community to bring about greater improvements in pollution control in Rhode Island.

He asked their aid in creating public opinion for better laws for the preparation and distribution of milk.

Mrs. Herbert E. Harris, President of the Auxiliary, presented a gavel to the Auxiliary.

Mrs. Robert Flanders brought greetings from the New Hampshire Auxiliary.

Our guest speaker of the day, Mrs. Luther H. Kice of Garden City, Long Island, President-Elect of the Woman's Auxiliary of the A. M. A., spoke at length on the work of the National organization.

Following the luncheon a business meeting was held.

The Secretary's report was read and a motion was made by Mrs. Edgar Potter and seconded by Mrs. Waldo Hoey that the report be accepted. Motion carried.

The Treasurer, Mrs. Jesse P. Eddy 3rd, reported a balance on hand as of April 30th of \$801.58 with a membership of 237. A motion was made by Mrs. J. Merrill Gibson and seconded by Mrs. Joseph C. Johnston that this report be placed on file. Motion carried.

It was moved by Mrs. Paul Cook and seconded by Mrs. William Davis that the reports of the Standing Committees be accepted as a unit.

Mrs. Bertram H. Buxton of the Organization Committee reported an increase of 61 members for the year.

Mrs. Herman Lawson reported for the Legislative Committee.

Mrs. J. Lincoln Turner reported for the Editorial Committee.

Mrs. Charles F. Gormley reported for the Program Committee.

Mrs. William N. Hughes reported for the Revisions Committee.

In the absence of Mrs. James P. O'Brien the Secretary read the report of the Public Relations Committee.

Mrs. Henry Hanley moved that these reports be accepted as a unit. Mrs. H. Lorenzo Emidy seconded the motion. Carried.

Mrs. Guy Wells, Vice-President, took the chair while Mrs. Herbert E. Harris, President, read her report. Mrs. Harris urged the Auxiliary to consider a nurses Scholarship Fund as a project.

A motion was made by Mrs. Bertram H. Buxton and seconded by Mrs. Edgar Potter that this report be accepted. Motion carried.

Election of Delegates to the Woman's Auxiliary of the A. M. A. followed. Mrs. Charles Ashworth and Mrs. Jesse P. Eddy 3rd were elected as Delegates. Mrs. Peter Pineo Chase amended that anyone else going should be made alternates.

Our Delegates were instructed to vote in favor of the increase in dues.

A motion that these Delegates be accepted was made by Mrs. Henry Hanley and seconded by Mrs. Robert T. Henry.

The President stated, prior to the submission of the Nominating Committee's report, that there could be counter nominations from the floor. She then desired to know the feelings of the members regarding balloting in such an event. A motion was made by Mrs. John J. Donley and seconded by Mrs. Bertram H. Buxton that in such an event the election be made by ballot. Carried.

Mrs. Paul Cook, Chairman of the Nominating Committee read the report of her Committee:

Mrs. J. Murray Beardsley—President

Mrs. Charles L. Farrell—Vice-President

Mrs. William Newton Hughes—President-Elect

Mrs. Henry J. Hanley—Secretary

Mrs. Jesse P. Eddy 3rd—Treasurer

continued on next page

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 Newport—Mrs. Alfred Tartaglino
 Bristol—Mrs. Arcadie Giura
 Kent—Mrs. Joseph C. Kent
 Washington—Mrs. Joseph H. Ladd
 The President asked for further nominations from the floor.

As there were no counter nominations, Mrs. Niles Wescott moved that these officers be elected. Mrs. Frank Hanley seconded the motion. The motion was carried. The Secretary cast one ballot electing these officers.

Mrs. Herbert Harris presented the gavel to the new President, Mrs. J. Murray Beardsley, and wished her and the organization a successful year.

Changes in By-Laws submitted by the Revisions Committee were then voted upon. A motion was made by Mrs. Henry Hanley and seconded by Mrs. H. Lorenzo Emidy that these revisions be accepted. Motion carried.

Next in order of business were the nominations and election of members of the 1949 Nominating Committee. Mrs. H. Lorenzo Emidy and her Committee of tellers checked the ballots. There were several nominations from the floor. The results of this Committee will be announced after the next Board meeting.

The meeting adjourned at 3:40 p.m.

Respectfully submitted,

MARY A. FARRELL, *Secretary*

RECORD LIBRARIANS ELECT

At the business meeting of the Rhode Island Association of Medical Record Librarians held during the annual meeting in May, the following officers were elected:

President: Miss Barbara Arnold of Roger Williams General Hospital

Vice President: Miss Olivia Brum, of Lying-In Hospital

Secretary: Miss Jane Lowe, of Lying-In Hospital

Treasurer: Miss Eleanor Murphy, of Rhode Island Hospital

Councillors: Miss Mary Nunez, of Pawtucket Memorial Hospital

Miss Sarah Litwin, of Miriam Hospital

INDEX OF ADVERTISERS

	PAGE
Abbott Laboratories	353
Alkalol Company	398, 402
Ames Company, Inc.	392
E. P. Anthony, Inc.	396
Ar-Ex Cosmetics, Inc.	407
Arlington Chemical Company	350
Ayerst, McKenna & Harrison	357
Bayview Convalescent Home	396
Blanding & Blanding	362
Borden Company	360
J. E. Brennan & Company	411
George A. Breon and Company	387
Joseph Brown Company	411
Buffington's, Inc.	386
Butterfield Drug Stores	408
Camel	356
S. H. Camp Company	351
Ciba Pharmaceutical Products, Inc.	349, 383, 399
Coca-Cola	393
Curran and Burton	400
Davies, Rose & Company	Inside Front Cover
Doho Chemical Corp.	389
Edgewood School	400
J. E. Hanger, Inc.	393
Langlais Health Institute	390
Eli Lilly & Company	Insert between 362-363
McCaffrey, Inc.	371
Mead Johnson & Company	Back Cover
Medical Milk Commission	387
Merck & Company	359
Meredith & Clarke, Inc.	395
A. B. Monroe Dairy	403
Mutual Benefit Health and Accident Association	352
Neland Pharmaceutical, Inc.	393
Owens-Corning Fiberglas	385
Parke, Davis & Company	381
	Inside back cover
Physicians Directory	405-406
Rhode Island Limb Company	394
Schering Corporation	391
G. D. Searle & Company	379
Smith-Holden, Inc.	354
Spencer, Inc.	404
Tilden-Thurber	395
Wander Company	358
White Rock Bottling Company of Rhode Island	394
Winthrop-Stearns, Inc.	361

APPOINTED COMMITTEES — 1948-49

The Rhode Island Medical Society

Committee on Cancer

George W. Waterman, M.D., *Chairman*,
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Joseph C. O'Connell, M.D., Providence
William Fain, M.D., Providence
Henry B. Moor, M.D., Providence
E. Victor Conrad, M.D., Providence
G. Raymond Fox, M.D., Pawtucket
James C. Callahan, M.D., Newport
James McCarthy, M.D., Woonsocket
Frank E. McEvoy, M.D., Providence
Herman C. Pitts, M.D., Providence
Isaac Gerber, M.D., Pawtucket
Adolph Eckstein, M.D., Providence
John Paul Jones, M.D., Wakefield
B. Earl Clarke, M.D., Providence
Hartford P. Gongaware, M.D., Westerly
Philip Batchelder, M.D., Providence

Committee on Child Health Relations

Earl F. Kelly, M.D., *Chairman*, Pawtucket
Henry E. Utter, M.D., Providence
Francis V. Corrigan, M.D., Providence
Harold G. Calder, M.D., Providence
Merle M. Potter, M.D., Providence
William P. Buffum, M.D., Providence
Jose M. Ramos, M.D., Newport
Isadore Gershman, M.D., Providence
Reuben C. Bates, M.D., Providence
Reginald A. Allen, M.D., Providence

Committee on Maternal Health

John G. Walsh, M.D., *Chairman*, Providence
Michael H. Sullivan, M.D., Newport
George E. Bowles, M.D., Providence
Alfred L. Potter, M.D., Providence
John F. Murphy, M.D., Providence
Richard H. Dowling, M.D., Woonsocket
Louis A. Morrone, M.D., Westerly
Henry E. Turner, M.D., Pawtucket

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REPORT ON THE AMERICAN ACADEMY OF PEDIATRICS CHILD HEALTH SERVICES STUDY

AS THE Rhode Island Medical Society contributed to the Child Health Service Study and as we earnestly desire its advice and approval, we are presenting a progress report.

The study consists in the collection of data, the tabulating of these data at the Academy national headquarters and then the presentation of the material by the Rhode Island members to the interested parties with critical analysis and recommendations.

The figures are grouped in four categories comprising the child health activities of medical schools, hospitals, public health agencies and organizations, and private physicians. The medical school study is on a national basis. This study was made by agents from the Academy Headquarters. The recommendation for government subsidy for medical schools is a highly controversial subject but as there are no medical schools in Rhode Island, the Rhode Island members of the Academy will not touch upon that in their report.

The study of the other three groups of figures, those on hospitals, public health agencies and organizations, and private physicians is the responsibility of the Rhode Island members of the Academy. The central office has tabulated the figures which we collected and is sending them to us for presentation. We are entirely independent in this and can be subjected to no pressure whatsoever from outside the state.

Dr. Henry E. Utter has accepted the chairmanship of the subcommittee on child care by private physicians. Dr. Harold S. Calder has accepted the chairmanship of the subcommittee on public health agencies and organizations and Dr. Banice Feinberg has accepted the Chairmanship of the subcommittee on hospitals. These chairmen will form committees of academy members and invite other persons who have special knowledge in the field to sit in with them at committee meetings.

In these subcommittee meetings the figures will be arranged to show their significance and if there are any wise recommendations which can be made they will also be presented. The Academy members will form the main committee and will present the report and be responsible for it.

If our report is to be of value it must have the approval of the medical profession in the state.

We urge anyone who does not understand or who has any criticism of our study to let us know his ideas about it. We shall keep the Rhode Island Medical Society informed of our progress from time to time.

It is impossible to say at this time how revealing or how valuable our report will be but you can be assured that we shall not make any recommendations for child health care without very careful consideration.

WILLIAM P. BUFFUM, M.D.,
Chairman for Rhode Island
American Academy of Pediatrics

April 26, 1948

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BOOK REVIEWS

SYMPOSIUM ON MEDICOLEGAL PROBLEMS. Edited by Samuel A. Levinson, M.D., PH.D., University of Chicago College of Medicine. *J. B. Lippincott Company, Publishers.*

This book of 249 pages is a review of meetings of the Institute of Medicine of Chicago and the Chicago Bar Association. The contents bring out, as the foreword states, "Because of the education and training that is given to the members of both professions and the opportunities inherent in their practice, they very clearly have a public duty to perform in the community. Those duties . . . extending into public welfare generally."

Among the problems discussed are Expert Testimony, The Medicolegal Implications of Artificial Insemination, The Medicolegal Problems of Pathology, Medicolegal Implications of Operations to Produce Sterility, Trauma in the Causation of Tumor, Blood Grouping in Paternity Cases, Chemical Tests for Intoxication.

The scientific presentation is made by medical men or men skilled in a scientific field and the legal viewpoint is presented by men learned in jurisprudence.

The presentations are excellently given and the legal viewpoint is excellently stated. The question periods allowed at the end of the presentations bring out diverse viewpoints, all of which are provocative of further thought.

The thing the scientific presentation seems to miss can be adequately expressed by the words of the late Justice Holmes viz: "The life of the law is not logic but experience". Experience frequently demands that we accept what is expedient rather than what is logical. However science may gradually disclose how logic and expediency may be more frequently reconciled.

The clash of the numerous private and social interests is well demonstrated. The natural bias of attorneys representing individual interests as against corporate and state interests is obvious in the questions put to the speakers.

Throughout the book it is ideal that there is full and open discussion — without thought of embarrassment by putting the other fellow "on the spot."

Of course, the whole field of medicolegal matters is not covered. To do so would take volumes. The present monograph, however, is an excellent beginning and might well serve as a model for future symposia conducted by the medicolegal associations of the several states.

J. Francis Daurman has finely prepared a foreword. The publishers have made the format of the book such that it is readable without fatigue. The speakers and their questioners have well discussed the problems presented and have left the reader with plenty of material for consideration.

Whether one appears in court or not, whether one is vitally interested in the subjects presented or not, the book is recommended for its stimulation of thought and also to show the practical difficulties that beset the reconciliation between that which is logic and/or expedient.

WILLIAM H. FOLEY, M.D.

"THE BATTLE OF THE CONSCIENCE"

by Edmund Bergler, M.D.—Published 1948,

Washington Institute of Medicine,
Washington, D. C.

This book discusses the conscience from the psychoanalytic viewpoint. The fact that much of the conscience is formed from the child's idea of what the authorities of childhood—chiefly the parents—desire, demand, and approve is well presented. This book stresses that there is no appreciation of the real difficulties or possibilities of life or of its limitations during the origin of conscience. It also emphasizes that guilt or dissatisfaction tends to occur when facts and your "conscience-concept" of yourself show a discrepancy. In other words your self-erected conscience gives you guilt for not achieving its goals.

The language and theories of the book were not easy for the reviewer to follow or understand. A person psychoanalytically trained might profit from reading the book. A person not psychoanalytically trained would probably gain little inspiration or insight.

WILLIAM NEWTON HUGHES, M.D.